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Thesis submitted to the  
UNIVERSITY OF EDINBURGH  
for the degree of Doctor of Medicine. 1915.

T I T L E .

Dementia Praecox  
in the Native Races  
of  
South Africa

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## I N T R O D U C T I O N .

In South Africa the study of the mental disorders occurring in the natives offers a wide field for investigation. Numerous problems of psychology and psychiatry present themselves to the worker amongst the kaffir insane.

In selecting Dementia Praecox in the native races of South Africa as the subject for this thesis I have been guided by various considerations. It is the most prevalent form of mental disease occurring in natives, and of itself accounts for approximately one-third of the annual admissions to native asylums. This fact alone makes it a psychosis of considerable importance to South African psychiatrists. Apart from this, Dementia Praecox for some years now has been a prominent subject for discussion and investigation by psychiatrists everywhere. It therefore appeared to me that a study of this form of mental disorder amongst the native races of South Africa would be both timely and profitable.

In pursuance of this plan I have adopted the following scheme.

Owing to the kindness of the Physician Superintendent I have been able to go thoroughly into the records in the case books of all cases admitted to the native section of Pretoria Mental Hospital during five years, 1909-1913 inclusive. From these cases I have selected all such as, in my opinion, on account of the symptoms shewn or the course followed, might legitimately be placed within the dementia praecox group. It is on these records that the statistical conclusions found in the text are based. They are in all cases original, and are vouched for by the actual figures. Otherwise I have relied upon close personal observation and examination of cases for the past eighteen months during which I have been in charge of the native section of Pretoria Mental Hospital.

I have interrogated and conversed with normal natives, and with white~~men~~ whose experience of the native is considerable; and I have made use of such scant literature as exists concerning the natives and their ways. By this means I have been able to gather a fund of information regarding the sane Kaffir, an essential to the proper understanding of the insane.



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There is not, so far as I am aware, any literature extant dealing with insanity in the native races of South Africa, but I have been fortunate in having opportunities of discussing this subject with different South African alienists, whose wide experience of insanity amongst the natives has enabled them to give me much valuable information.

Monographs dealing with the manifestations of dementia praecox in white races are plentiful. These and various text books have been freely consulted.

In the actual construction of this treatise the conception of dementia praecox, as published in the eighth edition (1913) of Kraepelin's "Lehrbuch der Psychiatrie" has been more or less closely followed. Kraepelin's conception of the psychosis is essentially a clinical one, and therefore one that lends itself readily to an investigation such as this. Moreover, his conception of the disease in white races is one that is widely accepted and therefore eminently suitable as a standard with which to compare certain deteriorating forms of mental disorder common in the natives of South Africa.

Does dementia praecox occur in the Kaffir?. If it does, how does it resemble, and how does it differ from this psychosis as observed in the white races?. These are the main questions to which this thesis is an attempt to find an answer.

I.

SOME POINTS CONCERNING THE  
MENTAL CHARACTERISTICS OF THE NORMAL NATIVE.

That the normal South African native differs markedly in his mental make-up from the normal European is a fairly obvious fact to all who have had any dealings with the kaffir. It is, however, rare to find anybody who is prepared to make other than vague and indefinite assertions when asked to define wherein lies this generally recognised difference.

Broad generalisations may be serviceable enough in most cases, but where, as in this thesis, a study of certain abnormalities of the native mind is the question at issue, it is desirable in the first place to endeavour to arrive at some definite conclusions concerning the mental constitution of the average native.

It is not proposed to make here any attempt at giving a full account of the normal psychology of the Kaffir. Various minor points, of importance to the psychiatrist, will be dealt with at a later stage as they happen to arise. The object of this chapter is merely to indicate

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briefly some of the more important and characteristic features of the native mind.

Of the various mental qualities that which is most singularly deficient in the native is the critical or logical faculty. This is due, in the first place, to the fact that the Kaffir, as an observer of phenomena, is hopelessly inaccurate. He is further apparently unable to distinguish between cause and effect. For example, he will argue that because he had toothache yesterday his cow fell into a hole and broke her leg today. To a European, accustomed to more or less scientific methods of thought, such a conclusion is manifestly absurd. But to a Kaffir, an entire absence of any connection between occurrences is no impediment to his associating them together in his mind. He does not trouble to reason things out. He jumps to conclusions. Post hoc is propter hoc.

This confusion of cause and effect gives rise to all manner of absurd mistakes, but the idea of experimenting, with a view to eliminating impossible theories, never occurs to him.



Many natives have little or no conception of the relative values of things. To such, a doll that falls asleep when laid on its back is just as wonderful as a motor car.

The imperfect development of the logical faculty is shewn markedly in yet another way. A native is capable of entertaining directly opposing and contradictory ideas at one and the same time. He may even signally fail to appreciate the discrepancy when it is pointed out to him. His ideas seem to be kept, as it were, in water-tight compartments, so that they can exist side by side without any sense of mental incompatibility. This state of mind is analogous to that frequently observed in Europeans, especially in the spheres of religion and politics. In the native however it does not confine itself to any particular sphere, but is a characteristic of his whole mental life.

It is astonishing how chaotic the mind of a sane Kaffir can be. For this reason it frequently happens that little reliance can be placed in his statements, even when he is telling what he honestly believes to be the truth.



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While he may thus unwittingly deceive he has at the same time no real sense of truth, and he may intentionally mislead the questioner. It is not that he has any particular objection to the truth per se. But he is above all things polite. He says what he thinks will be agreeable. He answers to please, not to inform. This is especially marked in his dealings with the white man, for whom he has a profound respect. If politeness and truth conflict, then he prefers to be polite.

Again, if it is to his interest to do so, he will lie deliberately. He sees nothing wrong in this. To deceive cleverly is a smart thing to do, but it is foolish to be found out.

If a native wishes to withhold information, it is impossible to get anything out of him by direct questioning. He is an expert in the art of evasion, and a past master in the method of using a multitude of words<sup>d</sup> without saying anything definite. He never commits himself if he can possibly help it. If he is eventually cornered he is either ready with some plausible excuse or retires behind a non-committal "I don't know".

It is, however, frequently possible to obtain from a native information which he does not wish to give by abandoning frontal attacks and resorting to indirect methods. By assuming a knowledge one does not really possess, and by taking him unawares, one can often succeed in getting hold of reliable facts.

It has been pointed out already how confused is the working of the Kaffir mind. It is therefore not surprising to discover that their power of introspection is non-existent, that they are unable to make any critical examination of their own mental processes. On account of this, while they believe a very great deal, they cannot tell you why they believe, or even very definitely what they believe, for they never consider or reflect on their beliefs.

Here then is a clue to the implicit faith of the native in the tremendous power of magic. It is the one subject upon which all Kaffirs are agreed. It is the cause of health, and success; of sickness, and misfortune; of anything that may befall. It is the one fundamental fact in the life of the Kaffir. To give

an account of the various forms and manifestations of magic, and of the manner in which these influence the native, is beyond the scope of this chapter. It is sufficient to note that magic is, to the native, an all-sufficient explanation for anything beyond his comprehension.

It may be pointed out here that natives cannot always distinguish between dreams and actual experiences. Sometimes they recognise dreams as such, but at other times they do not, and believe that the things dreamt of really happened. This probably accounts for a certain number of the impossible stories related by natives.

The power of memory possessed by Kaffirs is often remarkable, especially for facts which interest them. They have no written language to aid them, and therefore have to rely upon their memory to a degree rarely practised by white men. It must be remembered, however, that the native is a very superficial observer, and that his power of attention is small for anything that does not interest him. While he may thus have a marvellous memory for some facts,

for others his retentive power is considerably below that of an average European.

Emotionally the native is, as a rule, bright and cheerful, with a keen sense of humour. He has considerable power of restraint, and knows well how to conceal his emotions. Under certain conditions, this restraint is thrown off, and then he lets himself go with a vengeance. One gets the impression that his feelings are composed of highly inflammable material, which any appropriate stimulus may be sufficient to set alight. There is no coping with such a fire once started. It has to be left to burn itself out.

Both sexes are large-boned, well developed, muscular specimens of humanity. The men, especially the young men, are inordinately vain, and are thus very sensitive to ridicule. The women are free and unrestrained in their manner, and differ much in their sense of delicacy.

A Kaffir, compared with a European, has not nearly so acute a sensibility to pain. He is naturally cruel, and shows utter lack of consideration for the sufferings of animals.

He is devoid of aesthetic sense, and has no appreciation of beauty. He is rarely troubled with a conscience. Any tendency towards morality is effectively stifled by the debasing and obscene rites to which both sexes are subjected about the period of puberty.

Up to the age of puberty the native is intellectually the equal of the European child. After this age, however, in the vast majority of cases, he is left far behind by his white rival. He does not seem to have the capacity for further development.

The adult Kaffir, in knowledge, in mental capacity, and in character, is greatly inferior to the white man. He pursues through life an aimless course, trifling with time, taking little thought for the morrow, and having no ideal to strive after beyond a life of ease and sensual indulgence, and the satisfaction of his animal needs.



## II.

### ETIOLOGY.

In the investigation of psychoses in natives one encounters at the outset peculiar difficulties. In cases of mental disorder the anamnesis occupies an important position. Indeed, without such information, in some cases it is impossible to arrive at any definite conclusions. When a European is brought to an institution he is usually accompanied by a relative or some other person from whom facts can be obtained concerning the patient's family and personal history. Should such facts not be available on admission they can usually be got from reliable sources at a later date.

A Native however arrives at the Asylum under an escort of European or Native police, who in most cases have been in charge of the patient only a few hours, and who therefore know practically nothing about their charge. Communication with the relatives by means of writing is, as can be readily understood, hardly a feasible proposition. Sometimes they arrive at the Hospital and can be interrogated. It is difficult enough at times to get a history from unwilling relatives of a European patient. It is

infinitely more difficult to get this information from a Kaffir, who in such cases is suspicious to a degree, and resents what he considers an unwarranted interference with his private family affairs. Even when they are willing to give what information they can, their statements are of little value.

Hence for the previous history of a native one is compelled to rely on the legal form filled up by the Magistrate of the district from which the patient has been sent. These forms are only what they profess to be, legal documents. They do not concern themselves with the scientific aspects of the case. Consequently they are restricted to facts concerning age, tribe, previous occupation, religion, addresses of relatives, crimes committed, and so on. Even such facts cannot always be relied on and whenever possible they are checked by careful interrogation of the patient, or of the patient's friends in the rare instances in which they turn up to make enquiries. It is no unusual thing for a native to be admitted on a bare order, containing nothing but the name and necessary certificates. Even the name may be wrong, as,

for example, in one case that was admitted to the Asylum on three separate occasions, each time under a different designation.

These points are mentioned to show how extremely difficult it may be to get hold of definite information about an insane Kaffir.

An enquiry into the etiology of dementia praecox in natives is thus necessarily restricted in certain directions. There is available nevertheless a considerable body of facts which may help to throw some light on this aspect of the disease.

#### INCIDENCE.

The rate of incidence of dementia praecox has been estimated as a percentage of the total admissions. All the cases received into the Institution during the five years 1909 to 1913 have been taken, and the number of cases of dementia praecox amongst them calculated. The ratio has been worked out from the two sets of figures thus obtained.

The percentage of dementia praecox cases amongst the present inmates is, of course, very much higher, between 60 and 70 per cent.

This corresponds to what is found in all Institutions for the chronic insane, and is here, as elsewhere, dependent on the fact that this psychosis, though a chronic, is not a particularly fatal one, so that there is a tendency to the accumulation of this class of patient.

It may be pointed out here that, in addition to pure South African natives, the Hospital receives a certain number of Indians, Bastards (Cape Coloured), and Chinamen. The last three races in no way enter into this thesis. They have a different mental constitution, and in their psychoses exhibit symptoms differing markedly from those observed in the true native. Their inclusion would mean the introduction of many additional factors tending to obscure the issue, and therefore they have not been taken into account either from the statistical point of view or otherwise.

The figures contained in the following table (Table 1) refer only to pure natives.

Table I.

Dementia Praecox.Percentage of total admissions.

Year.	M a l e s .		F e m a l e s .	
	Total cases admitted.	Cases of D.P.	Total cases admitted.	Cases of D.P.
1909.	74.	27.	11.	7.
1910.	106.	36.	20.	6.
1911.	120.	45.	32.	13.
1912.	151.	57.	37.	10.
1913.	135.	49.	33.	11.
Total for 5 years.	586.	214.	133.	47.
%	100.	36.5	100.	35.3

Male and Female.		
Year.	Total cases admitted.	Cases of D.P.
1909.	85.	34.
1910.	126.	42.
1911.	152.	58.
1912.	188.	67.
1913.	168.	60.
Total for 5 years.	719.	261.
%	100.	36.3



A glance at the percentages shown in the above table makes the importance of dementia praecox in the native races of South Africa at once apparent. Here we find that roughly 36% of all cases of insanity in Kaffirs belong to this type. This percentage is considerably greater than that of any other type of insanity, the next commonest variety being Toxic Insanity due to dagga (Indian Hemp) with an incidence of 15 to 20%.

The various etiological factors are discussed under the headings, Predisposing and Exciting, as follows:-

#### Predisposing Causes.

1. Heredity. Physical Stigmata.  
Palatal Abnormalities.
2. Age.
3. Sex.
4. Occupation.
5. Education and Religion.
6. Tribe.

#### Exciting Causes.

##### Physical.

1. Toxic. Dagga and Alcohol.
2. Traumatic.
3. Exhaustion.
4. Bodily Disease.
5. Child-bearing.

##### Mental.

## PREDISPOSING CAUSES.

### 1. Heredity.

For reasons already mentioned the influence of the hereditary factor in the causation of dementia praecox in Natives cannot be gauged with any pretence to accuracy. The necessary sources of information are rarely available, and on this point the records are in most cases silent.

Of 261 cases of dementia praecox admitted during the five years 1909 to 1913, definite information was obtained only in seven cases. Four of these cases gave a positive history of hereditary taint, and three were definitely negative. Of the four positive cases, the first had a maternal uncle who suffered from delusions; the second's father had been an inveterate smoker of dagga (Indian hemp); the father of the third had been insane; and the fourth has a brother, admitted several years previously, and still in the Asylum, an excellent example of the last stages of dementia praecox.

It is useless to base conclusions on

such scanty material. In the absence of figures it is unjustifiable to take up any definite attitude. All that can be advanced is the opinion, unsupported by statistics, that in all probability heredity plays an important part in the etiology of dementia praecox in the Kaffir, but that there is no evidence to show whether this factor has an influence greater or less than that observed amongst the white races.

#### Physical Stigmata.

The question of physical stigmata is full of difficulties. Criteria suitable for Europeans do not apply to a less highly developed race. There are, moreover, in the South African natives, well-marked tribal differences, so that what is normal in an individual of one tribe may be abnormal in a member of another. With no definite standards by which to judge, only pronounced abnormalities can be considered.

Out of 205 cases in which the point has been gone into, 10 show distinct stigmata as follows:-

Unduly prominent forehead....	Two cases.
Very narrow head.....	One case.
Generally poorly developed and stunted.....	One case.
Imperfectly descended testes.	Two cases.
Supernumerary toe.....	One case.
Undeveloped lower jaw.....	One case.
Facial asymmetry. ....	One case.
Premature arcus senilis.....	One case.

#### Palatal Abnormalities.

Here again difficulties are encountered similar to those occurring in a consideration of the physical stigmata. Measurements are of little use in the absence of normal and tribal standards to guide one.

Out of 175 cases examined personally, only well-marked deformities have been noted as abnormal. They are included under the headings of "High and narrow" and "Flat".

Cases examined.....	175.
High and narrow.....	36.
Flat.....	13.
Total abnormal.....	49 i.e. 28%.

One of the cases included amongst the "high and narrow" shows well marked palatal asymmetry.

## 2. Age.

A native does not know how old he is, and he can rarely state his age in years. When asked, he will say that he has never thought of counting. A tolerably correct estimate can however be formed by making enquiries as to what he was doing, etc., at the time of some important occurrence in the country. If the dates of these are known, it is easy to calculate his present age from his replies.

The following are typical:-

"I was born at the time of the Zulu War" (Zulu War, 1879).

"I was just beginning to walk when the rinderpest began" (1896-1898).

"I had just grown up before the last Zulu War (Zulu Rebellion) (1906).

"I was so high (indicating a certain height) when the big war began" (Boer War, 1899-1902).

This method is not without fallacies, but is on the whole fairly accurate.

In the following table (Table II) the cases have been collected into groups according to the age on admission.



Table II.

Dementia Praecox. Admissions 1909-1913.

	Males.	Females.	Males & Females.
Total No. of cases.	214.	47.	261.
20 years and under.....	35.	5.	40.
21 to 25 years.	74.	16.	90.
26 to 30 years.	66.	14.	80.
31 to 35 years.	30.	9.	39.
36 to 40 years.	7.	2.	9.
40 years and over.....	2.	1.	3.
Total ages in years.....	5586.	1273.	6859.
Average Age.....	26.1	27.0	26.2

Youngest - 16 years.

Oldest - 46 years.

It is seen that the average age of onset is between 26 and 27 years. A considerable proportion of the cases occur before 20; the majority start between 20 and 30 years; after 30 there is a marked decrease in the incidence; and, as the figures testify, it is rare for the disease to commence beyond the age of 40. The lowest age of onset observed was 16, and the highest 46.

Age is therefore an important factor

in the etiology of dementia praecox. The statistics clearly show that this disease in natives, as in Europeans, is essentially one of puberty and adolescence.

### 3. Sex.

If Table I (p.19 ) is referred to, it will be seen that amongst the cases of all kinds admitted to the Institution, the males outnumber the females by more than 4 to 1. This <sup>is</sup> not to be taken as a true estimate of the relative frequency of mental disorders in the two sexes. While it is fairly certain that a considerable number of insane natives of both sexes escape certification, this applies to a far greater extent to females than to males.

The reasons are not difficult to find, Males, on account of their occupations, come into contact with the white man more frequently and in greater numbers than the females. They are therefore much more likely to be reported and certified. Moreover, in the Transvaal, the proportion of males tends to be abnormally high on account of the recruiting for mining purposes from

outside districts.

When a female becomes insane before marriage, the father does his best to conceal the fact. This is because every daughter is worth so many head of cattle to him. If it became known that she had been insane, he might be unable to find a man willing to buy her, and would thereby lose the "lobola" (purchase money) due to him by her husband when the girl is married.

A married woman is merely part of the goods and chattels of her lord and master. Her chief function is to produce children. Otherwise her value is nil. If she has borne her husband children, he considers he has received a fair return for the price paid to her father. If she is childless he regards his investment as a dead loss. In either case, if she becomes insane, she is not worth bothering about. Unless she is troublesome, no notice is taken of her.

Old women, past the age of reproduction, are things of no consequence, allowed to exist on sufferance. Nobody takes the slightest interest in them. If they are unable, through mental trouble, to look after themselves, so much

the worse for them.

This lack of respect for women is part of the religion of natives, and is due to their conception of a future existence in which women play a very subordinate part.

These factors tend then to reduce materially the total number of females admitted to the Asylum, and certainly account in large part, though not entirely, for the smaller rate. There is this additional factor to be reckoned with. Native women remain mostly in the kraals, where they can lead an uneventful, plethoric existence. The men, on the other hand, come much oftener into contact with the influence of civilisation and education, where they encounter novel surroundings and conditions of life for which they are mentally unsuited. These points are gone into more fully in the next section, which deals with the influence of occupation.

In discussing the sexual predisposition it is best to consider only the cases of dementia praecox admitted from urban areas. Practically all insane town natives are certified, whether male or female, and so it is possible to

arrive at a more accurate estimate of the incidence in either sex.

In Table III (p. 30), in which the town cases have been separated from the country cases, it is found that 129 males and 25 females are from urban districts, giving a ratio of 5.1 to 1. Now in these districts male natives greatly out-number the females. In the Census of 1911 the proportions for the sexes in Transvaal urban areas are given as 92.25% males, and 7.75% females, roughly 9 to 1. The ratio of 5.1 to 1 is not therefore a true one, and must be corrected in accordance with the proportions of the sexes. The true ratio is thus 0.6 to 1. That is to say, the actual rate of incidence per head of each sex in urban areas is for females practically double what it is for males. This is important, for it means that, given similar conditions, a female native has two chances of becoming insane to a male's one. In short, females, because of their sex, are more predisposed to mental disorder, whereas males, though they develop insanity more frequently, do so not on account of their sex primarily, but because, being males, they are more



exposed to adverse influences in the course of their occupations.

#### 4. Occupation.

The influence of occupation as a predisposing factor depends not so much upon the work itself as upon the locality in which the work is performed.

In the following table (Table III) , the figures have been arranged under the headings of Town and Country. The average number of admissions per annum of cases of dementia praecox has been worked out for urban and rural areas and for the sexes separately, and the rate of incidence per 10,000 of the population calculated in each case in accordance with the statistics given in the 1911 Census returns for the Transvaal.

Table III.

Dementia Praecox Admissions 1909-1913.

Previous occupation.

F e m a l e s .

<u>Occupation.</u>	<u>Town.</u>	<u>Country.</u>
Housewife.....	6.	15.
Domestic servant..	10.	-
Laundress.....	3.	-
Vagrant.....	2.	1.
Not stated.....	4.	6.
<u>Totals.....</u>	<u>25.</u>	<u>22.</u>
Average admissions		
per annum.....	5.0.	4.4

M a l e s .

Occupation.	Town.	Country.
General Labourer.....	37.	18.
Mine Labourer.....	43.	2.
Farm Labourer.....	-	54.
Houseboy.....	20.	1.
Shopboy.....	2.	-.
Peasant.....	-.	3.
Stableboy.....	3.	-.
Railway worker.....	1.	1.
Vagrant.....	3.	2.
Not stated.....	20.	7.
Totals for 5 years....	129.	85.
Average admissions per annum.....	25.8	17.0

	Males.		Females.	
	Town.	Country.	Town.	Country.
Total popula- tion (Census 1911).....	312,100	422,000	35,800	495,100
Average number of Dementia Praecox admissions per annum.....	25.8	17.0	5.0	4.4
Rate of incidence per 10,000.....	0.82	0.40	1.38	0.10

In the cases of the males it is seen that town workers show a rate of incidence double that for country workers. It may be thought that this higher rate for urban districts can be accounted for by the more thorough supervision of town natives, making the certification of any who

become insane an easier and a more certain matter. It is true that, if a town native develops insanity, his chances of being certified are considerably greater than is the case with his brother of the country in a similar state. Undoubtedly this tends to make the disparity between the two rates appear greater than is actually the case. It is not however the sole reason for the difference. The incidence is actually higher amongst urban dwellers.

A study of the causes at work makes this quite intelligible. When a native leaves his kraal and starts work in a town, he enters what is to him a new world. The easy-going, humdrum existence of the country becomes a thing of the past. Competition is keener; life is more strenuous; the struggle for existence is more in evidence. Vice is rampant in the larger towns, and a native picks up dirt by instinct. He is free from any little restraint that exists in the tribe, and, as has been aptly said, "the virulent germs of his nature find a suitable nidus for a quick culture". Unnatural conditions such as these are bound to have a detrimental effect on the stability of his nervous system, and must

in many cases be an important factor in the production of mental disorder.

The ratio of town and country cases is slightly higher for dementia praecox than it is for all cases, in the former 1.4 to 1, and in the latter 1.2 to 1. This may be explained by the fact that town workers (mine labourers, houseboys, etc.) are chiefly male kaffirs about the age of adolescence, at which age the largest number of dementia praecox cases occurs.

According to the table, the greatest number of cases in the town class occurs amongst mine and general labourers. Their work is arduous, their hours are long, and the physical strain to which they are subjected may readily act as an additional predisposing factor. But the prominence of these two groups is rather to be accounted for by the fact that they form the bulk of town workers. The figures show that the number of farm labourers admitted exceeds that of any other class of worker. Undue significance need not be attached to this. It is not to be wondered at, and depends simply on the fact that many more natives are engaged in this

class of work than are to be found in any other occupation. The vast majority of male kaffirs in country districts are farm labourers, and rural dwellers form approximately 60% of the entire male population. The actual type of labour engaged in is of secondary importance. The real factor is the environment.

If the statistics for females given in Table III are now considered, it will be observed that the rate for town dwellers is very much higher than that found for country dwellers, in the former 1.38 per 10,000, and in the latter only 0.1. The unfavourable conditions of environment noted in connection with male town workers are also in operation here, and though not perhaps to the same extent, still with more effect, on account of the greater predisposition to the psychosis shown by females. This sexual factor was discussed in the previous section, when it was contended that, under similar conditions, females become insane about twice as often as males. This is borne out by the rates of incidence observed in the two sexes in urban areas, for males 0.82 per 10,000, and for females 1.38, almost double. The rate of incidence for



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females living in country districts is seen to be very low, only 0.1 per 10,000. This is quite misleading; the real figure is probably very much higher, between 0.5 and 0.6. The factors tending to reduce the number of female admissions have already been dealt with in this chapter under the heading of sex (pp.26-27). These factors apply for the most part to rural districts. It is difficult for a female lunatic to escape certification if she happens to be living in a town. If she is employed by white people her commitment to an institution is practically certain. In any case it is not easy for her to evade for any length of time the watchful eye of the police. In towns then concealment and neglect of insane women have but a slight chance of success. In the rural districts however such methods obtain full scope, and this accounts very largely for the small number of cases admitted from country areas.

Taking everything into consideration, it may be concluded that, as a predisposing etiological factor, occupation is of importance more from the point of view of its site than of

its nature; that where a native works is of greater significance than what he works at; and that all occupations necessitating living in or in proximity to large centres of civilisation have, on account of the unhealthy environmental conditions prevalent at such centres, a distinctly adverse influence on the native mind.

#### 5. Education and Religion.

Education and religion fall naturally under the one heading. Generally speaking a native is either a Christian with a certain degree of education, or a pagan and uneducated. Up to the age of puberty he shows a distinct aptitude for assimilating new ideas. During the period of adolescence there is however a pronounced retardation of his mental development. A striking contrast is thus afforded between adolescent natives and Europeans, for it is precisely at this time of life that the growth of intellect and character becomes so marked in the latter. To account for this stunting of the native's mental powers it has been assumed by some that his potential energy for development

does not suffice for both body and mind, and that its force is expended on bodily functions, nutritive and sexual, to the detriment of his nervous system. Whether this is the true explanation or not, the fact remains that after puberty a Kaffir shows normally a definite mental retrogression. This inherent racial characteristic is not sufficiently recognised by religious and educational workers amongst the natives, and with the best of intentions they try to instil into minds incapable of dealing with them, conceptions and problems too many and too complicated.

Further it must be pointed out that it is essentially the emotional side of religion that appeals to Kaffirs. They rejoice in meetings of an ultra-revivalist type. They revel in the emotional orgy that these provide. Such excesses tend to produce nervous instability, and are often bad for the character of the people.

So far as can be discovered, about 15 to 20% of natives have accepted Christianity. It is therefore significant to find that of 213 cases of dementia praecox in which the facts can be ascertained, 125 are Christians and only 88 are Pagans. These figures are strongly suggestive of the dangers of "forced culture" to

individuals unable to react adequately.

It is as well however not to confuse cause and sequel, and to bear in mind the possibility that a certain mental instability may be present before they become Christians. It may be that, on account of this very instability, they embrace the more readily the new and strange doctrine; just as white schizophrenics, in art, in literature, and in religion, tend to seek what is novel and fantastic, and to follow the cult of the bizarre.

#### 6. Tribe.

To obtain satisfactory statistics concerning the relative frequency of dementia praecox in the various native races of South Africa it would be necessary to know the total population of, and the number of dementia praecox cases occurring in each tribe. In the absence of any such figures the tribal percentages have been calculated according to the number of total admissions. Such a method is of doubtful value, and it is to be feared that no conclusions

can be come to on this basis.

The following table (Table IV) gives the figures obtained.

Table IV.

Dementia Praecox; Tribal Incidence.

Tribe.	Males and Females.		
	Total Admissions 1909 to 1913.	Cases of Dementia Praecox	Percentage.
Basuto.	315.	122.	35.6
Zulu.	79.	21.	26.6
Xosa.	52.	15.	28.8
Swazi.	55.	21.	38.1
Shangaan.	75.	31.	41.3
Nyambaan.	13.	3.	23.0
Ndebele.	29.	8.	27.6
Hottentot.	27.	9.	33.3
Bechuana.	12.	5.	41.6
Other small tribes.	62.	26.	
	719.	261.	



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Exciting Causes.

Physical.

1. Toxic, Dagga and Alcohol.

Dagga (Indian Hemp) is largely used by natives on account of its intoxicating action. The weed is smoked in one of a number of different ways, to produce an agreeable feeling of elation, or to overcome the fatigue caused by hard manual labour. For this latter purpose many mine boys use it regularly as a constitutional pick-me-up, before turning out to work. They say it makes them feel very strong, and that they do not become so soon tired. The wisdom of employing such artificial stimulation is doubtful in the extreme. Indeed, within recent years South African alienists have recognised that the smoking of dagga is of no little importance in the etiology of mental diseases in natives. The abuse of this drug not only gives rise to a special form of toxic insanity, but such abuse is also capable of acting as the exciting cause in other varieties of mental disorder.

In dementia praecox a history of

excessive dagga smoking is frequently found. Alcoholism is less common, probably on account of the laws prohibiting the sale of intoxicating liquors to natives. A kaffir can get dagga whenever he wants it; alcohol he can only obtain with difficulty and by stealth. In some of the cases dagga smokers are also alcoholic, and the two causes cannot always be differentiated.

The following table (Table V) gives the number of cases in which a history was found of dagga, or alcohol, or both.

Table V.

Dementia Praecox: Dagga and alcohol as an exciting cause.

Males.	Admissions. 1909 - 1913.	Dagga.	Dagga & alcohol.	Alcohol.
Cases.	214.	21.	10.	15.
%	100.	9.8	4.7	7.0
Females.	Admissions. 1909-1913.	Dagga.	Dagga & alcohol.	Alcohol.
Cases.	47.	3.	0.	0.
%	100.	6.4	0.	0.

It is seen that in 9.8% of the male

cases dagga is the exciting cause. In the females the percentage is lower, 6.4%. Among natives however it is not considered to be the proper thing for women to smoke dagga, and so they do not indulge in the vice to the same extent as the men. The consumption of alcohol is also a privilege of the male sex, and in no female case is a history of alcohol found. In 7% of the male cases however the outbreak of the psychosis can be definitely attributed to the abuse of alcohol; and to a combination of dagga and alcohol in 4.7%.

Thus in over 20% of the males the mental breakdown is found to have been preceded by a definite toxic poisoning. The question is whether the abuse was the cause of the psychosis, or the psychosis the cause of the abuse. It is certainly reasonable to suppose that the alcoholism, or the dagga smoking, was merely one of the first symptoms of the loss of control; that the disease was already in progress when the excesses were begun; and that, while the toxic effect of the drug might have exacerbated, it did not act as the true exciting cause of the mental disturbance.

But it is also allowable to assume that others were not insane at first, and that indulgence served to convert a potential into an actual psychosis.

Many natives smoke dagga daily for years without exhibiting any definite mental abnormality, or any tendency to excess. Others, again, readily overstep the bounds of moderation, or show, even with ordinary doses, an abnormal reaction. Like alcohol, dagga is a test of the stability of the individual. In a Kaffir predisposed to insanity the use of either may be followed by serious consequences. Whether the addiction to the drugs precedes or follows the onset of the disease is of secondary importance. The fact that no less than 20% of the cases give a history of excess is sufficient to justify the conclusion that dagga and alcohol are important causes in the etiology of dementia praecox in natives.

## 2. Traumatic.

In five instances the onset of marked symptoms was preceded by some bodily injury. In three cases head injuries were noted, one of

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these a fracture of the skull. In another case the patient sustained injuries to his eyes from an explosion of dynamite. Progressive impairment of vision resulted, accompanied by a mental condition of a paranoidal type. The fifth case became insane shortly after he had been struck by lightning.

### 3. Exhaustion.

In three cases an indefinite history was obtained of weakness and prostration before the actual onset of mental symptoms. It is probable however that these were cases of bodily disease, unseen by a medical man, and undiagnosed. In this case they would properly be included under the next group.

### 4. Bodily Disease.

Bodily disease was the exciting cause of the outbreak of the psychosis in four cases. Two were admitted after fever (malaria), one after influenza, and one during convalescence after enteric. In all four cases the mental symptoms commenced during the attack, and their commitment to the asylum was occasioned by the continuation of the mental disturbance after



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the disappearance of the pyrexia.

#### 5. Child-bearing.

In the female sex child-birth is an important etiological factor. Out of 47 cases admitted, no less than 11 commenced during this period. 4 cases occurred during pregnancy, 3 of them hebephrenics, and 1 catatonic. Of the remaining 7, in which the puerperium furnished the exciting cause, 4 were of the catatonic variety, 3 of the hebephrenic, and 1 paranoid. It would seem then that the puerperium favours the catatonic type of the disease, and pregnancy the hebephrenic.

Two of the puerperal cases might also be placed under the heading of "Exhaustion".

#### M e n t a l .

In an endeavour to estimate the part played by mental stress in the etiology of dementia praecox in natives, certain points have to be borne in mind. As has been pointed out already, definite information concerning the previous history of a native is difficult to obtain. Further, relatives will never suggest a mental cause as the reason for the outbreak.

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They cannot conceive of such a thing, but attribute the insanity to magic. As a matter of fact, usually they do not consider their relative to be insane at all, but only bewitched. And they are frequently very anxious to take the patient away from the institution, so that they may employ a Kaffir doctor to break the spell.

It is not therefore surprising to find that a definite mental cause was discovered in only nine cases. It is however significant that study and religion are held as responsible for seven of the nine, while the remaining two are due to the sudden death of a husband and of a wife respectively. This bears out the views already expressed in the section on Education and Religion (p.37 ), and is additional proof of the inadvisability of overburdening the native mind.

#### Discussion on Etiology.

Now that the various factors have been gone into in detail, it is possible to discuss the etiology as a whole.

The influences of heredity and tribe require to be eliminated, on account of the lack

of material whereon to base conclusions. Age is important, the disease being essentially one of youth. Sex is also worthy of note, for, ceteris paribus, females show double the susceptibility of males. Occupation, in so far as it entails life in town, and too advanced education, by overtaxing the nervous resources of the individual, are also influential factors. Dagga and alcohol in the male sex, and child-bearing in the female, likewise occupy a prominent position as causative agents.

All these points have been fully discussed already, but there has been suggested hitherto no definite reason why certain natives, exposed to the same conditions as their fellows, should become insane, or why they should develop dementia praecox rather than another type of insanity. Evidently there must be in operation some other factor not yet dealt with.

Two very divergent views exist concerning the origin of dementia praecox. Kraepelin and his adherents hold that some form of auto-intoxication, probably originating in the sexual glands, is responsible for the disease. The other school have an entirely different conception

of the disorder. Following the teaching of Freud, Jung, and Adolf Meyer, they maintain that the psychosis is due to mental factors, occasioned by the stress of civilised life; that the malady develops in certain individuals on account of their inability to meet frankly the numerous mental problems encountered in a complicated environment, and especially because of their unhealthy attitude towards sexual difficulties. They submit that such persons do not meet their troubles squarely, but are prone to indulge in unhealthy substitutes for normal reactions, and to get rid of their difficulties by repressing them; and that it is this repression of painful ideas, this abnormal mental reaction, which is the prime cause of the mental disorder.

It is difficult to see how this latter theory can be applied to many of the cases of dementia praecox occurring among the natives of South Africa. A considerable proportion of the cases occur in Kaffirs living in a primitive condition of existence, and leading a simple life in the kraals. There is here no strenuous civilisation, no complicated environment with

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which to contend. Special stress has been laid, by the advocates of the mental theory, on the importance of the sexual instinct. They assert that the control of this instinct, rendered necessary by the conditions of modern society, is attained by certain individuals in an unhealthy way; that sexual problems are not confronted and disposed of, but are thrust into the region of the unconscious, where they continue to exist, as complexes; and that the symptoms of the psychosis are merely the outbreak of these complexes in a disguised and symbolic form.

This may be perfectly true for civilised races, but we are not here dealing with such. Kaffirs, in their natural state in the kraals, can scarcely be said to deal squeamishly with the problems of sex. Indeed, after cattle, sexual matters form the staple of conversation. Altogether, so little is control of the sexual instinct thought necessary or desirable, there is no need for repression. It is difficult to understand how, under such circumstances, complexes are going to be formed. Yet, in these raw Kaffirs, dementia praecox is by no means rare. This appears to favour the theory that the



fundamental cause of the malady is not mental, but due to some disorder of metabolism, resulting in an auto-intoxication.

It is interesting to recall in this connection that Fauser in 1912, and afterwards numerous others, in applying Abderhalden's reaction in cases of mental disease, found, in the blood serum in cases of dementia praecox, specific proteolytic ferments capable of destroying the cells of the sexual glands, and of the cerebral cortex.

It is true that dementia praecox occurs with greater frequency in those natives who live in towns and are in contact with civilization. It is quite possible that the control over the instincts, rendered necessary by such an environment, may cause repression of these instincts, with resultant complexes. Such a view cannot be entirely discarded. It is more than likely that the symptoms in some cases assume a particular form because of this. But the theory of mental causation does not explain all cases; it does not explain the cases in the kraals.

It has already been pointed out that the mental development of normal Kaffirs tends to stop short at the period of puberty and adolescence, and it is easy to conceive that the bounds of physiology may be overstepped in some instances, and that a pathological condition may result, not merely a standing still of brain development, but an actual retrogression. This may to some extent be an explanation of the frequency of dementia praecox as compared with other psychoses in natives. It has been suggested by some that the normal stoppage is due to the development of the sexual and nutritive functions at the expense of the nervous. If this is so, - and it seems a reasonable proposition - it means that the normal arrest in the growth of the native mind is to be attributed to some obscure but physiological condition of metabolism occurring at the adolescent period. This physiological condition may become pathological, and give rise to a disorder of metabolism, a condition of auto-intoxication, acting injuriously on the nervous system.



These views are of course purely hypothetical. All that can be said is that some unknown factor is at work. In some instances this of itself may be sufficient to produce an outbreak of the mental disorder. In other cases additional factors appear to be necessary, alcoholism, occupation, and so on. These do not of themselves give rise to the disease, but merely co-operate with the essential factor, and, by weakening the resistive powers of the individual, precipitate the onset of the psychosis.

### III. GENERAL SYMPTOMATOLOGY.

#### A. Mental Symptoms.

It is difficult, in a systematic enquiry into the mental symptoms, to know in what order they should be considered. Any scheme is more or less arbitrary. On account of the interdependence of the various spheres of mental activity, it is not possible, in discussing one, to exclude the others. Overlapping cannot be avoided, and consequently many of the symptoms mentioned under one heading in

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reality come under several.

In the following pages the most constant and characteristic abnormalities are dealt with first. These include disorders of the Association of Ideas, of Affectivity, and of Conduct and Volition.

Hallucinations and Delusions are considered next. Though the presence of either is not essential for the recognition of the psychosis, they occur with sufficient frequency, and in characteristic enough forms, to make them a feature of the disease.

Disturbances of Consciousness, Attention, Comprehension, Orientation, Answering, and Judgment, are considered last. They may be regarded as secondary, and are in many instances dependent on disorders of the first and second groups.

## GROUP I.

### (a). Association of Ideas.

A certain proportion of the cases show no apparent interference in the association of ideas. They are coherent, answer relevantly, and give a good account of themselves generally.

In the majority there is observed a certain looseness of association, varying from slight confusion and contradictoriness, to complete incoherence. All natives are inclined to be rambling and contradictory, and allowance has to be made for this, in estimating the degree of disturbance. In stuporose conditions, the train of thought appears to be in complete abeyance. Occasionally a patient talks well at one time, and at another used gibberish, a mere jumble of meaningless sounds. Neologisms are also met with. Words are coined, which the patient can give no explanation of; or he may refer to commonplace objects by special names of his own. For example:-

Case C.208. - Says he owns large tracts of land in the Groot Spelonken. It is being kept from him by the "ramaraimitcha". (He could give no explanation of this last word. None of the native attendants had heard of it). Shown pictures of goose and turkey, said they were "jumpers".

Some patients converse clearly and rationally until the subject of their delusions is touched on, when they become confused and



incomprehensible.

Another characteristic feature is the **sudden** interpolation of an entirely irrelevant remark into the conversation.

For example:- Case 3244. - In the middle of a sentence he will suddenly break off, thus :- "It is on your nose and will burn you". "Do you see that white dog? . I never went with it. It was my brother."

The following example shows well the confusion in the association of ideas, and the lack of any apparent connection between the thoughts expressed.

Case C.130. - After four months in the Asylum this patient, though still insane, was discharged on probation for six months to the care of her relatives, as they were very anxious to try her outside. Within three weeks she was brought back to the asylum, as she had been very excited, violent, and resistive, and could not be managed. She was religious. The following notes were taken a short time after her return:- Gives a correct account of her last stay here, so far as dates are concerned, and of her time on probation. Asked why she had been so troublesome

when on probation, she said that her brother insulted her. He said, or rather implied that she was silly. It is not quite clear how her brother insulted her. When asked about it, she goes into a long-winded and utterly irrelevant explanation, thus:- "Q. "What/makes you think your brother insulted you"? A. "Well, it was this way. I am part of the Madrin-Unity, that is, the Madrin-Trinity of the Church of England, and one day my cousin -- ". Q. "But how did your brother insult you ?". A. "Well, he slapped me because his heart was broken. All the family's hearts were broken, because we were between two ham and eggs". Q. "What do you mean by that?." A. "My mother was working in the P.W.D. office in Pretoria, and his girl lived in Johannesburg, and when she was coming along, she was saved, and this was too much for him to carry upside down in his heart." Q. "Are you a very good woman ?". A. "I am a very good worker with my father and mother". Q. "Are you very religious?". A. "Why should I say that?.

After I went away with my sister, I sent a letter to the Father, and when he came, my brother, I

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didn't want to see him, because what shall he do then to me,. He shall drive me with a knife the whole time between nine and ten, and I was fighting with a knife, I was fighting with a table centre, and then I ran away to court."

Frequently the incoherence is much more marked. For example:-

Case. C.123. - He keeps up a disconnected flow of remarks in English and Sesutu. At times he will chant a single line such as, "I don't know where he is now," for prolonged periods. It is impossible to gain any history from him. The following is a type of his incoherent remarks:-- "You know God bring me here. Before I go the papers must be finished. I don't know why I done it. All this one I see is nothing. Who told you the boy can't. Have you already finish. Say no, say yes. Today, today, today. I don't know where I is. Somebody's God. etc."

There is a distinct tendency in many to harp on the same ideas and phrases. This is well shown in the following example.

Case C.230. - On coming into the office he indulged in curious movements and

gestures. Bent back in an opisthotonic fashion, and maintained this attitude for a minute or two. Then carried on a conversation with some imaginary person, thus :- "Oh, yes. What is that?. This is Johannesburg. Oh, yes, yes, yes. I give a pass for coffee. Yes, yes, I do that. Yes. I love coffee much. You see the coffee love me much. All right. Ja. You finish it all the time. You give me same. Rich my cousin die a long time. You give me coffee. Rich my cousin. Yes, I like that in train. I go Kimberley asking where is coffee. It is one month now the coffee. Yes, following Kimberley. Oh, no. Yes," and so on.

Of all the cases of dementia praecox examined, 86% showed desultoriness of the stream of thought in greater or less degree. The actual figures are contained in Table VI.

Table VI.

<u>Dementia Praecox. Association of ideas.</u>		
	Cases.	Approximate percentage.
Total.....	261.	-
Coherent.....	37.	14.
Confused and Contradictory.....	112.	43.
Incoherent.....	89.	34.
In abeyance.....	23.	9.

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(b). Emotional Tone.

The emotional tone on admission is usually one of apathy. No interest is displayed in the novel surroundings, and there appears to be a complete indifference as to what is going to happen.

Many show "autismus", a symptom on which stress is laid by Bleuler in Aschaffenburg's "Handbuch der Psychiatrie". They are "shut-in", self-sufficient, and do not respond affably as most natives do when taken notice of. In judging the emotional reaction, it has to be remembered that a normal native conceals his emotions, and may appear at first sight to be apathetic.

In dealing with white people, one of the first questions to be decided is whether the patient's attitude towards his relatives and his former interests has changed in any way, for a definite change of attitude is very characteristic of the early stages of dementia praecox. Unfortunately with natives this question can rarely be answered. Relatives are not often available, and, when they are, do not give much help in this direction.



A certain percentage of cases are at first sight depressed and apprehensive, and a somewhat smaller percentage are exalted. Both the depressed and exalted tend, as the disease progresses, to settle down into apathy. Sometimes the mood varies abruptly. A patient may laugh heartily one moment, and weep bitterly the next, and all without apparent cause. They are occasionally irritable, flying into a passion on the slightest provocation, or with no provocation at all. Underlying all the various emotional disturbances, there can be detected, in the vast majority of cases, a very definite emotional deterioration. In spite of a clear appreciation of their surroundings, they display little or no initiative and voluntary activity. It is true that a sane Kaffir is an adept in the art of killing time, and takes things pretty much as they come, but these patients are abnormally inactive, even for Kaffirs. They do not indulge in the thousand and one petty occupations by means of which a normal native occupies his day. They simply stagnate.

Table VII contains the figures in connection with the emotional tone on admission.

Table VII.

<u>Dementia Praecox.</u>	<u>Emotional Tone.</u>	
	<u>Cases.</u>	<u>Rough Percentage.</u>
Total.....	261.	-
Apathetic.....	165.	63.
Exalted.....	38.	15.
Depressed and Apprehensive...	58.	22.

(c). Psychomotor Reaction.

Decrease of psychomotor activity is frequent, and varies from a slight retardation, to complete inaction. That this is not a true retardation is shown in various ways. A patient may take a long time to answer a question, and yet reply to the following one quickly and promptly. They do not speak in a low voice, and halting manner, but readily or not at all. Occasionally sudden actions are performed, even in the midst of profound stupor, indicating that the defect is more of the nature of the blocking of impulses, than of a real executive retardation. Movements are not retarded. They are rather misdirected

or suppressed. In excited conditions there appears to be a more ready release of impulses than is usual, but the actions are apt to be purposeless and stereotyped. There is no typical pressure of activity.

(d). Conduct.

Conduct varies enormously, from the wildest excitement, to the most intense stupor. Excitement usually manifests itself by an incessant expenditure of activity, dancing, shouting, uttering of weird sounds, grimacing, gesticulating, and incoherent chattering. There is throughout a tendency to the performance of meaningless and stereotyped actions, out of harmony with anything in the environment. There may be intense loquacity with little motor activity; or the reverse. Stuporose cases lie abed paying no attention to anything. They do not seek food, or attend to the excretory functions. They may maintain fixed attitudes for hours at a time. Often they are resistive and strenuously oppose any interference. They require to have all their wants attended to.

Between the extremes of excitement and stupor there are all grades. One of the chief characteristics is a certain silliness, evidenced by absurd antics, gestures, and postures, accompanied by meaningless grimacing. A spasmodic, mirthless laugh is common, and was noted in 25% of the cases. These patients are generally unsociable, and keep to themselves - a most abnormal thing for a Kaffir to do. They are often mischievous, snatching food from another patient, although they have plenty of their own. They are unreliable, and prone to make, without provocation, sudden and senseless attacks, for which they can give no explanation. They may in the same way refuse meals for a day or more, and suddenly commence to eat again voluntarily. Occasionally they mutilate themselves. One patient has repeatedly attempted to cut off his toes, because "they were in the way". Another patient scratches small circular sores on his arms, and asserts that they are sovereigns. Their habits are often degraded. They are frequently foul-mouthed and abusive. They show, especially in the catatonic variety of the disease, negativism, automatism, etc.; these questions are dealt with

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more fully under the heading of "Volition". They are often affected, and display mannerisms of speech, gait, and so on.

Speaking broadly, the striking feature of their conduct is its unnaturalness.

In Table VIII the cases have been classified roughly according to the type of conduct exhibited on admission.

Table VIII.

Dementia Praecox: Conduct on admission.

	Cases.	Rough Percentage.
Total.....	261.	-
Normal.....	10.	4.
Excited.....	66.	25.
Silly and unreliable...	103.	39.
Dull & Stuporose..	82.	32.

(e). Volition.

In most cases there is considerable volitional disturbance. There is usually a marked lack of initiative, dependent, apparently, on the emotional deterioration. In the early stages this manifests itself in a tendency to



inaction, and by the absence of any directed activity. Too great stress must not be laid on this symptom. The average native, at his best, does not show much initiative. He will go through the same routine day after day with machine-like regularity, without considering why he does it, or what he can do to alter it. There are however in dementia praecox distinct deviations even from this somewhat low normal standard. These, though difficult to describe, are nevertheless sufficiently obvious to be appreciated by those who have a knowledge of native character. More marked symptoms appear in the shape of impulsive acts, negativism, stereotypy, and automatism. They are found in all varieties of the disease, but are most characteristically developed in the catatonic form.

Impulsive acts were noted in 54% of the cases. They occur without warning or provocation: the patients cannot explain their conduct, or they offer inadequate and absurd reasons for it.

For example:- Case 2192. - Tore a hen to pieces "because it worried him".

Case 2557. - Shortly before admission he suddenly attacked a white woman in the street, striking her on the head. He recollected the event clearly, but could not say why he had acted in this way.

The most frequent impulsive act of these patients is to make sudden and unprovoked attacks on inoffensive individuals. They lash out blindly at anyone who happens to pass them, or make an unwarranted assault on a harmless patient who is taking no notice of them. Their respect for the white man is, however, so great, that attacks on white members of the staff are extremely rare. Impetuous and ill-directed efforts to escape are also frequent. Other common acts of an impulsive nature are to rush round the yard, to snatch food from others, to break windows, to utter sudden and piercing yells, to throw themselves down suddenly, or to mutilate themselves in some way. Suicidal impulses are somewhat rare, - and were observed in only five cases.

In those cases in which negativism is exhibited, it occurs most frequently as a passive resistance to interference of any kind. The patients do nothing for themselves, and will not allow anything to be done for them. They oppose dressing and undressing. They do not take their food when offered, though they may take it half an hour afterwards. They often refuse to take food at all for a couple of days. Sometimes it is necessary to use a gag and feeding cup. The nasal or the oesophageal tube is rarely necessary, and was employed in only seven cases. They may resist being examined physically, and refuse to co-operate in any way. When they are wanted to move from one place to another they may have to be pushed or carried, and yet at other times they may walk about readily. Sometimes they hold the saliva in the mouth for hours, or they may refuse to perform the excretory functions. They tend to be seclusive. They sit in a corner with their heads covered up, or lie on the ground with their faces to the wall.

More definite negativistic signs occur on occasions. They may keep their jaws clenched while speaking, and mumble through closed

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teeth, or they may refuse to speak at all. They may stand with their backs to the questioner, and walk backwards into and out of the room. They may shut their eyes when asked to open them, press their lips forcibly together when asked to show their tongues, and so on.

Negativism is usually accompanied by signs of muscular tension, which may be slight or extreme. This is shown in a tendency to adopt fixed attitudes, by a retraction of the upper lids, a constant frown, pursed lips, and a resistance to passive movements. In extreme cases the patient lies curled up in bed, with his eyes tightly closed, his lips in a condition of "snout-cramp", and his fists clenched. He resists strenuously all interference, and requires to be forcibly fed. 49% of the cases showed evidences of negativism and muscular tension.

Automatism, or hyper-suggestibility, was encountered<sup>er</sup> in 20% of the cases. All Kaffirs are very suggestible, inasmuch as they will agree with leading questions, especially when asked by a white man. But in dementia praecox the

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suggestibility manifests itself in an abnormal way, as a repetition of words spoken or actions performed by another (echolalia and echopraxis), and by the presence of catalepsy. These symptoms occur especially in the catatonic variety of the psychosis.

Perseveration, the tendency to repeat the action aroused by the first stimulus, is occasionally observed, especially in the matter of speech.

For example:- Case 2840.- Asked, "Do you like this place?" answered, "Yes, sir".  
Q. "What is your name?". A. "Yes, sir".  
Q. "What place is this?". A. "Yes, sir".  
Answered "Yes, sir" to every question.

At a later interview, asked "Where do you come from?" A. "I come from home."  
Q. "How long have you been here?" A. "I come from home".  
Q. "Are you quite well?".  
A. "I come from home". and so on.

Stereotypy occurred in 35% of the patients. The same actions are repeated incessantly without reason or purpose. They may be more or less simple, such as nodding of the head,

swaying of the body to and fro, shrugging of the shoulders, spitting, walking in circles for hours at a time, turning round and round on the same spot, stamping the feet, and gesticulating. The speech may be affected in a like manner. The same phrases are repeated incessantly, and are sometimes the only words spoken.

For example:- Case C.176.- This patient had one stereotyped phrase, "N'sebenzanga" (I have never worked), which he repeated from morning to night. He chanted it, whispered it, answered questions with it, and only on the rarest occasions employed other words.

Stereotypy is also shown by the presence of mannerisms of all kinds in speech and action, as the following examples show:-

Case 2236.- Always clicks noisily before commencing to speak.

Case 2267.- Walks in a peculiar mincing way, and steps over lines.

Case 2465.- Claps her hands as she walks, keeping time with her steps.

Case 2772.- Every morning, on leaving the ward, he pirouettes rapidly three or four times. Frequently makes barking noises.



Case 2879.- He bends down every few yards as he walks and touches the ground with his hand.

In severely demented cases there is an entire absence of voluntary activity, and the patients lead a purely vegetative existence.

## GROUP. 2.

### (a). Hallucinations.

Illusions are common, even in normal natives, on account of their defective critical faculty, and it is seldom easy to say whether an illusion is or is not a symptom of mental disorder.

For example, a patient, who had been admitted somewhat late in the evening, complained the following day that a white devil had come into his room, grasped him by the wrist, and made flashes of light in the ceiling. This proved to be nothing more alarming than the visit of the European night attendant. The flashes in the ceiling were due to the switching on and off of the electric light. It is easy to understand how the sudden mysterious appearance of a light in the room would suggest magical practices to

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a raw Kaffir.

For practical purposes illusions may be disregarded, though probably in many instances they are evidence of insanity.

Care has to be exercised not to confuse dreams with actual hallucinations. Many natives cannot distinguish between dreams and waking experiences, and it may require, with some patients, a prolonged examination before a decision can be arrived at. Others state, without being asked, that they were only dreaming. Then a patient may appear to have definite hallucinations, which, on enquiry, are found to be actual happenings. He may mislead his interrogator by his desire to answer with perfect truth, as the following account shows:-

Q. "Do you ever hear anything strange at night?". A. "Yes." Q. "What do you hear?". A. "They talked too much, and shouted, and sang." Q. "Who were talking?". A. "I don't know." Q. "Were they talking to you?" A. "I don't know". Q. "What were they talking about?". A. "I don't know. They talk all kinds of languages." Q. "Did you see the people?". A. "No." Subsequently it was dis-

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discovered that the noises that had troubled him were caused by the removal of an excited patient to a single room.

Amongst the cases of dementia praecox examined hallucinations were found in 44%. This percentage does not include doubtful cases, or those in which the presence of hallucinations was only suggested by the patient's conduct. If these are considered too, considerably more than half the total number were hallucinated. Unpleasant hallucinations predominated, no less than 76% being of this nature.

Auditory hallucinations are commonest. Their nature varies considerably, from mere indefinite noises, buzzings, and ringing in the ears, to more complicated ones, where animals utter their cries, people and spirits talk, and the voice of God is heard. Usually the voices are accusatory or terrifying, but sometimes they are laudatory, and proclaim to the patient that he is a very good man, a prophet, and so on.

The following are examples:-

Case 2501. Complained of the constant clanking of chains.

Case 2809. Paul Kruger speaks to

him. Says he must go back to his home.

Case 3351. Boys in the mine used to call him names, and since admission to asylum, patients are always shouting at him, calling him lazy, a thief, etc.

Case 3437. Rumbling noises in ears.

Case C.8. A Girl from his home, and dead people, speak to him. They call him names.

Case C.23. The stars, the moon, the trees, etc. speak to him. They say all sorts of things. That he is a prophet, a very rich man, etc.

It is characteristic of many of these cases that they cannot give any account of what the voices say, though they hear them regularly.

For example:- Case 2836. Jesus talks to him. He is not quite sure what about.

Case 2982. Hears voices. Knows what they say to him, but cannot remember.

Case 3098. Hears voices at night. Cannot tell what they say.

Case 3155. People shout at him. Does not know who they are, or what they say to him.

Visual Hallucinations are rare alone, though they often accompany those of hearing. In only one case was there evidence of hallucinations of a purely visual nature. This patient (No. 3475) complained that at night she saw the intestines of sheep hanging around the walls.

A combination of auditory and visual hallucinations occurred in a little less than half the number of those hallucinated. God, ghosts, and human beings appear to the patient, and converse with him. These experiences, like the purely auditory ones, are usually of an unpleasant nature. The visitants malign and threaten to kill the patient. In a certain number they are agreeable. Sometimes they vary in nature in the same patient, being at one time pleasant, and at another terrifying. They are frequently fantastic and absurd. Occasionally the patient hears himself discussed disparagingly by the voices.

For example:- Case 2212. Hears voices talking about him, saying he is afraid of being shot. At nights people, in the shape of cats and snakes, come to him, and scream at him.

Case 2599. Complains that other patients make noises like a goat, and look at him with a bad eye to bewitch him. At nights he sometimes hears birds whistling and singing, and it is very nice.

Case 2651. Jesus appears to him and talks to him. Tells patient he must get himself killed. He sees Jesus better with his right eye, but cannot explain why. Jesus is a white man, with a long beard. At a later date this patient no longer saw Jesus, but "spooks, that make whistling noises. They look like paper".

Case 2787. Three ghosts, one donkey, one corpse, and one living person with a goatskin hat, come through the window at night, run round, and make weird noises to frighten him.

Case 3194. Saw the "King of the town" on the roof, who talked to him. Could not remember what he said.

Case C.98. God, yellow and like a snake, speaks to her, and says she must be killed.

Apparently in some instances the experiences are of the nature of pseudo-



Pseudo-hallucinations. It is difficult to be sure of this in a native. He is not likely to appreciate their subjective nature after the manner of some white patients, or doubt, as some of the latter do, their external reality. Occasionally, however, he says that the voices talk to him very softly, from far away, or that they speak to him through his heart.

For example:- Case C.142. When he listens very hard, he can hear people speak to him from home, very softly.

Case C.174. He sees his brother with his heart sometimes at night. His brother talks to him from the kraal. Patient cannot remember what he says, but thinks he speaks about girls.

Hallucinations of common sensation occurred in a few cases.

For example:- Case 2388. Hears voices saying she is a devil, a bad woman, etc. She feels birds pecking inside of her, and snakes moving about.

Hallucinations of taste and smell were also met with occasionally. They were always of an unpleasant nature.

For example:- Case 2939. She hears

people talking about her. They come to her at night, pull the blankets off, and beat her. They poison her food. She can taste the poison in it. They stink.

The hallucinations for the most part are fleeting and variable. In two-thirds of the cases they occurred at intervals during the day and night; in the remaining third only at night. They are found to be most marked during the acute or subacute onset. Later they tend to disappear, or, if they persist, the patient, in most cases, takes little notice of them.

Table IX gives the actual figures on which the foregoing observations are based.

Table IX.

Dementia Praecox: Hallucinations.

Cases investigated - 261.

	Un-		
	Total.	Pleasant.	pleasant.
Cases with Hallucinations.....	118.	28.	90
Cases with only Auditory Hallucinations..	65.	15.	50.
Cases with only Visual Hallucinations.....	1.	0.	1.
Cases with Auditory and Visual.....	52.	13.	39.
Cases in which Hallucinations of smell and taste occurred.....	5.	0.	5.
Cases in which Hallucinations of common sensation occurred..	8.	0.	8.

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Cases Hallucinated during day only.....	0.
Cases Hallucinated during night only...	35.
Cases Hallucinated during day & night...	83.

(b). Delusions.

In all kinds of insanity in natives delusions, if present, are apt to be colourless and monotonous. This is dependent on their lack of education. Their stock of ideas is small, and the poverty of their mental life is reflected in their insane beliefs. One of the commonest delusions in an exalted patient is that he is a chief, has enormous herds of cattle, large tracts of land, and dozens of wives. Another frequent delusion of grandeur is that of being a white man. Elated mine boys own gold and diamond mines. Christian Kaffirs, with tiresome regularity, consider themselves prophets. Depressive delusions are similarly circumscribed. Patients with such complain that they are beaten and ill-treated, or that people wish to poison them, or to kill them. Very often they say they are bewitched. This last belief is not necessarily an insane one. All natives believe

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in bewitchment. But a sane Kaffir only believes he has been bewitched when anything untoward happens to him. An insane Kaffir believes it when nothing has happened. The insanity lies in the fact that he believes that certain things have happened, or are happening, to him. That he should explain his imaginary experiences by bewitchment is perfectly normal.

In dementia praecox delusions are encountered in the majority of cases. Of those examined 64% expressed delusions of some kind or other. It is likely that many of the remainder were also subject to delusions, which, for various reasons, could not be elicited.

The delusions are mostly of a depressive or persecutory nature. As a rule they are vague and silly. They are often accompanied by hallucinations in harmony with the beliefs. Frequently they are fleeting and changeable. The patients complain that people are trying to harm them, and fear their enemies will kill them.

For example:- Case 2433. - Patient complains that natives, whom he cannot specify, have broken his left arm, injured his legs and

body, and destroyed his left eye. He shows no signs of injury.

Case 2873.- The other boys, who worked with him on the mine, bewitched him with invisible medicine. His jaw felt tied up.

Case 2893.- (Governor's pleasure patient, who had murdered his wife). States that for over a year the indunas have been trying to poison him and kill him. They wanted to make medicine from his fat. He struck his wife with an axe because she was always going to the indunas and making plans to kill him. The police boys in gaol also wanted to kill him. He heard them talking about it.

Case 3215.- Complains that he is always being followed about by police boys, who say, "Catch him." There are 1000 of them. Says he was born with all his organs upside down, and he has been sent here to have them put right.

Quite commonly the delusions refer to the immediate environment, and the actions of attendants and patients are misinterpreted.

For example:- Case 2491.-- Before he came here his brother poisoned him, and since

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coming, one of the native attendants has tried to do the same.

Case 3155.- Everybody in the yard is trying to do him harm.

Case 2890.- She states that her husband has got tired of her, and is always persecuting her. The other women in the yard are constantly talking about her, saying she does no work and eats all the food. They are always doing things to annoy her.

Delusions of physical influence are occasionally present. Delusions about electricity, telepathy, hypnotism, and other malign agencies of a like nature, are not met with in natives, as they are in Europeans. A native knows nothing about such things, and so, of course, is not in a position to frame delusions concerning them. When he does complain of being influenced in any way, he invariably ascribes it to some form of bewitchment.

For example:- Case 2651.- States that he has a worm inside his head, which crawls around and makes him feel queer. He cannot shut his eyes when it moves. The worm came out of a fly that was put into his head by a witch-doctor.



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Delusions of the mind being influenced are very rare in natives. They do not complain of their thoughts being controlled by others, of evil things being put into their minds, or of being suddenly deprived of their thoughts. Such delusions are not uncommon in European schizophrenics, and are said to be important and characteristic symptoms. Natives, however, have such a poor conception of their own mental processes, that they cannot be expected to form delusions of this nature. Even when asked about such things, they do not understand what is meant.

If they had such experiences, they would only be able to state somewhat indefinitely that their heads were queer, and would attribute this to the agency of spirits or magic. It seems not unlikely, however, that in natives mental phenomena occur similar to those which are present in some white schizophrenics, and which give rise to such delusions as "thought-pulling," etc. This feeling of external interference with the thought processes appears to be shown in the following cases:-

Case 3492.) Patient states that God has tied a rope to his head, and is constantly pulling on it. The rope is attached to the inside of his head, and cannot be seen. God uses the rope to draw patient's attention to some object or other, e.g., "There are birds," "There is a fly," etc.

Delusions of a hypochondriacal nature are rare. They were observed only in five cases. The patients, though in good physical health, complained that they were very ill.

For example:- Case.C.177.- States she is very sick, that she is full of disease, and that her body is full of little holes.

Delusions of self-accusation and sinfulness are also very rare. Only three cases expressed such. This is to be attributed to the unmoral nature of the Kaffir, and to the feeble development of his conscience. He seeks outside of himself for explanations of his condition.

Expansive delusions occur from the first in a fair proportion of the cases. Like those of a depressive nature they are often

accompanied by corresponding hallucinations. They tend to be absurd. They may be stable, but often they are changeable and vague. The patients believe they are chiefs, white men, or prophets; that they are very rich, or very powerful; and, probably on account of their great respect for old age in men, they express not infrequently the delusions of great age.

For example:- Case 2152.- Says the sky is made of water, and that he came from the sky in a boat. He has enough money to fill the office.

Case 2517.- He is a chief. He is a King with twenty servants. He owns a large store at Potchefstroom, where he employs many white and black people. He has plenty of money, because all the native boys pay their taxes to him. He is twenty thousand years old.

Case 2608.- He is a thousand years old. He was the first man on earth. He had no father or mother, but grew out of the ground like a potato. He was made in England out of the earth. He used to be white, and was able to speak English, but has forgotten the language.

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Case 2514.- He is a prophet. He  
is dead and in heaven.

Case 2794.- He is Jesus Christ. He  
has to see that the sun does not burn the earth.  
He sends the clouds, and the rain, etc.

Case C.98.- She has many kraals,  
innumerable cattle, and a white child.

Case C.230.- All things on earth  
are his children. The sky, the stars, the moon,  
and the sun are all the sons of a bitch, and  
the bitch belongs to him.

In a certain number of cases a  
combination of depressive and grandiose delusions  
is found.

For example:- Case 3066.- He is a  
big chief, and he is to be killed.

Case 3259.- People want to poison  
him, because he makes too much money. They are  
jealous of him.

Case C.127.- People humbug him.  
They want to kill him, because he is a great  
chief, a Scotsman, and has lots of money, cattle,  
etc.

At times the delusions are very  
fantastic and ridiculous.

For example:- Case 2787.- States he is invisible when he stands against the wall.

Case 3152.- She is a tree. She does not require food, but grows from the ground like a tree. Says that her leg is cut off.

As the psychosis progresses, the delusions tend to become more vague and indefinite, and ultimately to disappear. In some cases they persist throughout, but for the most part in a confused and altered form.

The figures concerning delusions in dementia praecox are found in Table X.

Table X.

Dementia Praecox:- Delusions.

	<u>Cases.</u>	<u>Rough Percentage.</u>
Total.....	261.	-
Depressive and Persecutory.....	86.	33.
Expansive.....	42.	16.
Indefinite and Fleeting.....	38.	15.
Delusions not elicited.....	95.	36.

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GROUP. 3.

(a). Memory.

A certain amount of difficulty is experienced in estimating memory defects in natives. Their memory for remote events cannot be tested, as in Europeans, by an examination in knowledge presumably acquired at school, because very few of them have been to school. It is also rare to obtain facts concerning their previous life, whereby to gauge their retention. By careful questioning, as to where they were born, where they lived as children, etc., and by checking the answers at subsequent interviews, it is possible to estimate approximately what degree of defect exists.

Memory for recent events can be tested much more accurately, by questions concerning statements contained in the certificates accompanying the patients, and by their memory for events during their stay in the institution.

Of the cases examined 40% showed no appreciable memory defect; 28% showed deficiency, chiefly for recent events; and 32% were generally impaired.



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defective impressionability, estimated by simple tests, such as the ability to enumerate after a short period a few common objects shown, was found to occur in the majority of cases showing impairment of memory for recent events. This appears to indicate that such impairment is due primarily to the defective impressionability. On account of the emotional deterioration and lack of interest, occurrences are not attended to, and therefore are not remembered.

A few cases showed a tendency to fabrication.

(b). Consciousness.

Consciousness is usually clear, but in excitement and stupor there may be variable degree of clouding. Many cases, however, show a surprising clearness in the midst of acute excitement.

For example:- Case 3551. This patient was readmitted to the Institution after five months absence. On admission, "He is very restless and excited. His conversation is extremely irrational and irresponsible. He is,

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however, correctly oriented for self and place, is able to state exactly how long he has been here, and recognises and names several of the staff".

Case C.123.- On admission. "He came into the office dancing and whistling; immediately began to gesticulate and posture. He is very resistive; refused to answer any questions or to obey any command. It is practically impossible to gain his attention. His conversation is extremely incoherent." A month later he had become somewhat quieter, and it was noted, "He recollects several of the incidents since his admission, telling of his father's visit, how many people were with him, etc."

The same recollection of events is found frequently after recovery from stupor.

Of the cases of dementia praecox admitted during five years, 56% had clear consciousness, 26% showed slight confusion, and 18% marked clouding.

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(c). Attention.

A native's power of voluntary attention is not good. He is not able to concentrate his mind on things which do not interest him. His attention is very like that of a child, readily gained, but not easily held. It is necessary therefore not to expect too much from him in this direction, and to judge him by native and not by European standards.

In dementia Praecox a pronounced impairment of attention is noticeable. Questions have to be repeated many times before an answer is elicited. Incidents in the environment pass apparently unheeded. The chief defect lies in the difficulty with which the attention is aroused. 52% of the cases showed this in a greater or less degree. In a certain number of excited and stuporose cases, the attention could not be gained in any way. A few showed distractibility, their attention being gained readily enough, but being readily attracted by objects or happenings round about.

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(d). Comprehension.

As a rule external impressions are correctly apprehended. Simple tests, such as the recognition of common objects, coins, and pictures, show that there is, in the majority of cases, little disturbance in this field. A certain amount of latitude has to be allowed in making tests of any kind with natives. For example, patients do not always recognise the doctor as such, but can only say he is a chief, or a white baas. This does not indicate deficient comprehension, but is simply a reflex of the education of the individual. Many Kaffirs have never heard of the existence of such a place as an asylum, and so they do not at once grasp the true nature of their environment.

About 25% of the cases showed distinct inability to comprehend simple external impressions. It was in excited and stuporose conditions that such defect was usually noticeable.

(e). Orientation.

In dealing with orientation it has to be remembered that natives are usually very hazy in their estimate of time. They do not reckon, unless they are well educated, according to day and date. They sometimes know what year it is, or what month. More frequently they know the day of the week, but practically never the day of the month. They count the passage of years by the seasons, summer and winter, by the sowing and harvesting of mealies, and often, curiously enough, by the number of Christmases. After a few days they can give only an approximate estimate of the lapse of time.

Here is a typical account of an examination of a patient after four weeks in the Institution:- Q. "What year is this?".

A. "I don't know". Q. "Is it summer or winter?".

A. "Summer." Q. "What day is it?". A. "Thursday, I think" (Tuesday). A. "Are you sure?".

A. "No". Q. "How long have you been here?".

A. "I don't know". Q. "How long do you think?".

A. "A long time". Q. "A week, or a month, or

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a year?". A. "About three weeks, I think, .The baas must know. He writes it all down in the book".

Disorientation for time is not then in a Kaffir of the same significance as it is in a European, and is often no indication of mental disorder.

The same does not hold for place. Natives have a good conception of direction and locality. They do not however always know the names of places, even the Kaffir names. An asylum is an unknown quantity to most of them, and is usually considered a compound, or a prison. They may fail at first to give the name of the town, for the excellent reason that they are not told where they are going, and because, as they commonly say, it is the first time they have been in the place. At the end of a week however a normal Kaffir will have discovered fairly accurately where he is. If, at the end of this period, a patient is still disoriented for place, it can safely be assumed that he is in some way abnormal.



Amongst the cases of dementia praecox investigated, 51% were correctly oriented; 11% showed some slight impairment; and 38% showed considerable defect. Disorientation was usually observed in those cases which were excited or stuporose. It is probable that the percentage of correctly oriented patients is really considerably higher than is shown above. But the examination of a native in an acute excitement is a difficult matter, and it is often by no means easy to be sure that the findings on such point as this are correct. And in many stuporose patients it is <sup>m</sup>impossible to obtain information on this or any other question, until the stupor has in some degree abated.

(f). Answering.

A perfectly normal native is inclined to be evasive in his replies to questions, if he does not wish to give information. Also, he does not tend to be too precise in his answers at any time. Evasiveness, and approximate answering (Ganser's symptom) must not therefore

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be considered too readily a sign of mental disorder.

Certain peculiarities in the manner of answering are found in cases of dementia praecox. A patient may answer well and promptly at one time, and at another refuse to make any reply whatever. He gives no explanation of such conduct, which appears to be dependent on the disturbance in volition. Other characteristic abnormalities are found, on account of the disturbances in other fields. Complete irrelevancy, dependent on the incoherency of the train of thought, is frequent.

For example:- Case 3569.- Q. "What place is this?". A. "Cape Town." (Pretoria).  
Q. "What is wrong with the boys in the yard?".  
A. "The boys are sick. I cannot hear".  
Q. "Is anything wrong with your ears?".  
A. "Water. Water.". Q. "Are you married?".  
A. "This is one place". Q. "How old are you?".  
A. "I know nothing, only ra, ra, ra, ra,".

Sometimes the patient gives a silly and irrelevant answer to a question, which, on repetition, he replies to correctly. He cannot

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explain why he does this.

For example:- Case 2422.- Shown picture of a crocodile, and asked what it was, said, "It's a thing that once ran away." A snake he said was "A thing everyone kills." Asked what it was called, said, "I don't know". Q. repeated. A. "A snake". Q. "What is your name?". A. "My teeth." Q. "What place is this?". A. "Myself." Q. repeated. A. "Hospital". Q. "Why did you not say so at first?". A. "I don't know". Q. "Do you see anything strange at night?". A. "No." Q. "Do you ever hear voices when you cannot see/anybody?". A. "Since I have been here I have pulled my jacket off." Q. repeated. A. "No.". Q. "How long have you been here?". A. "How can I say?. I see bricks about, and people".

Occasionally the patient, while replying readily, exhibits negativistic traits, and refuses to answer the questions asked.

For example:- Case 3227.- Asked if she liked this place, said, "No, I don't know. I don't know why I am here. You people read books. You ought to know". Q. "Does anything

trouble you?". A. "What troubles me should be known to you. You read books, and write."

Q. "Are you sick?". A. "You are supposed to know that, You read books." Q. "Do you sleep well?". A. "That is not for me to say. You know that. You read books." Q. "Do you ever hear people speaking to you at nights?".

A. "Don't worry me any more. That's for you to find out". Q. "How can we tell that?".

A. "You know whether my heart is happy or not. I've been here a long time, so you ought to know".

The use of stereotyped expressions, as the above example also shows, and echolalia, occur not infrequently. In conditions of excitement the patient may chatter incessantly. Questions are not heeded at all. There may be, in stupor, complete mutism. Many patients never utter a word voluntarily, and yet reply readily and intelligently when spoken to.

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(g). Judgment. Insight.

At the best a native's judgment is a poor thing. His critical and logical ability are feebly developed; he does not weigh the pros and cons. So it is difficult to say in a given case of insanity if there is any impairment of judgment. It is necessary to rely on simple tests, by means of which only gross errors can, of course, be detected. A patient should be able to recognise the abnormalities in the mental conditions of the patients in the institution. A sane Kaffir does so at once. Many of the cases of dementia praecox fail, however, even in this simple test of judgment, and deny that the other patients are in any way mentally unsound. Many of them state that the others are sick, or have fits, but rarely suggest that they are insane. Though they often admit it, when it is put to them in the form of a leading question, this is not of much value, on account of the tendency of natives to answer what they think is wanted, rather than what they think is the truth. By simple tests of this nature, it was found that over 80% of

the admissions showed distinct impairment, compared with what might be expected from a normal native.

This deficiency is shown also by the ridiculous reasons sometimes advanced for their conduct.

For example:- Case 2400.- This patient had been violent before admission, and had broken furniture in a Missionary church. His explanation for this behaviour was that the church and furniture were old, and he thought if he broke them up they would get new ones.

These patients very rarely have true insight into their condition, even when they recover. This is not surprising, when it is considered how little a Kaffir observes his mental processes. They often admit that they have been sick, but seldom that they have been mad. Most frequently they believe they have been bewitched. As a rule during the disease they indignantly deny that anything is wrong with them at all. As the psychosis progresses, the judgment is found to become increasingly worse.



An observation may be made here concerning a symptom mentioned by Bleuler in his treatise on dementia praecox in Aschaffenburg's "Handbuch der Psychiatrie". He states that a schizophrenic is able to harbour opposing and contradictory ideas in his mind at the same time without recognising their mutual antagonism. This symptom he terms intellectual "ambivalency". A perfectly sane native, however, probably on account of his loose methods of thinking, may show this symptom. For example, he may complain of a pain in his chest, and consult a Kaffir doctor, who, with much ostentation, apparently removes a small lizard from the painful part. The patient may know he is being humbugged, and yet be convinced that the lizard was the cause of the pain, and was actually taken out of him. He believes and does not believe at the same time. The presence of "ambivalency" cannot therefore be considered in a native a characteristic schizophrenic sign.

#### (h). Habits.

A Kaffir is not a refined person, and many of his habits are disgusting to

Europeans. He is however, according to his lights, rather particular about the care of his person. In dementia praecox there is a distinct falling off in this direction. Only 26% took a normal interest in their appearance; 32% were slovenly and untidy; and 42% wet and dirty in habits at some time or other, especially during excitement and stupor.

Some collect rubbish, others eat filth, many are destructive, and a few show bad habits such as plucking out the hair, scratching themselves into sores, and so on. In spite of the gross sexuality of the native, masturbation is comparatively rare, though homosexual tendencies are more frequent.

The deteriorating nature of the psychosis is indicated by the fact that no less than 74% of the patients showed some lapse from the normal native standard.

#### (i). Sleep.

At the commencement sleep as a rule is apt to be broken, especially in states of excitement. Later the patients sleep soundly

for the most part, though in some cases hallucinations are troublesome.

Generally speaking, natives are not subject to insomnia nearly so frequently as Europeans.

#### B. Physical Symptoms.

##### ---General.---

The bodily health was not as a rule markedly affected. Of the cases examined, the health on admission was good in 55%, fair in 37%, and poor in 8%. Pulmonary tuberculosis was the usual cause of the last.

The state of nutrition corresponded pretty closely to the condition of the bodily health. Some cases were emaciated from neglect, refusal of food, or excitement.

The temperature was found to be normal in most cases where no physical disease was present. It was a degree or more lower than usual in 28 patients, and a degree or more raised in 7.

Circulatory.

The pulse rate was usually between 70 and 90. Occasionally it was unduly slow; more frequently the rate was markedly increased.

Of 212 cases, the pulse rate was in six cases below 60, the lowest observed being 48; and in 27 cases over 100, the highest being 150, though the temperature here was only 97°.

Other evidences of circulatory disturbances were met with at times, in the shape of impurity or reduplication of the heart sounds, epigastric pulsation, and soft systolic murmurs. There was irregularity of the heart in seven cases. Cyanosis is not apparent, of course, in a native, but cases of stupor usually had a weak, flabby pulse, and indistinct heart sounds, indicating a sluggishness of circulation.

Profuse sweating, and copious salivation were observed in a few cases. Dermographia was not encountered.

### Alimentary.

Evidences of intestinal derangement, indicated by a more or less thickly coated tongue, were found in the vast majority of cases. The appetite, however, was usually good. It is rare for insane natives not to take their food well.

### Urinary.

In five cases a trace of albumen was found in the urine, apparently due to the presence of Bilharzia.

### Nervous.

Generalised epileptiform convulsions were noted in seven cases. In one case the spasm was localised in the muscles of the neck.

Syncopal attacks occurred in four patients. Fine tremors, affecting chiefly the face and hands, were observed in eight, and well marked fibrillary twitching of the facial muscles in 15.

The deep reflexes were abnormal in about half the cases. Of 228 patients examined the response was normal in 121 (54%), increased in 67 (29%), and decreased in 40 (17%).

Out of 237 patients pupillary symptoms were present in about 20%. The pupils were dilated in 15 instances, contracted in 14, and unequal in 4. The reaction both to light and on accommodation was sluggish in 12 cases, and in three the pupils responded feebly to light, directly and consensually, though they contracted briskly on accommodation.

### C. Course and Termination.

These questions will be discussed later, when the separate varieties of the disease are considered. In the meantime, it may be noted that, of all the cases of dementia praecox examined, only 6% recovered completely, and 11% incompletely, while 14% died. 17 out of 37 deaths were due to tuberculosis.



Table XI gives the actual figures  
for the five years, 1909-1913.

Table XI.

Dementia Praecox: Termination.

		<u>Rough</u>	
		<u>Cases.</u>	<u>Percentage.</u>
Total admitted 1909-1913.....		261.	-
On De- cember 31st, 1914.	(Completely recovered.....	16.	6. )
	(Incompletely recovered.....	30.	11. )
	(Unrecovered.....	178.	69. )
	(Died.,.....	37.	14. )
			17%.

#### IV. VARIETIES.

Kraepelin, in the eighth edition of his Text Book (1913), subdivides the three types of dementia praecox, formerly described by him, into eight main clinical forms. For the purposes of this thesis, the older classification has been adhered to. Even when dealing with Europeans there is often, with this latest classification, considerable doubt as to which group any given case should be placed under. With natives the difficulties are much greater. They have to begin with a comparatively simple mental constitution. Their psychoses are consequently in many ways less clearly cut than in Europeans, and do not lend themselves readily to elaborate differentiation.

The cases have therefore been considered under the three varieties, Hebephrenia, Catatonia, and Paranoid. The symptoms found in all three have already been dealt with fully under General Symptomatology. No object will be served by discussing these symptoms in detail a second time. It is proposed therefore merely to give a brief outline of each of the three

types, indicating the mode of onset, course, and termination, and to append to each variety illustrative cases.

#### A. Hebephrenia.

This form of dementia praecox is the one most frequently met with. Out of 214 male, and 47 female cases, 114 (53%) and 26 (55%) respectively, were of this type. The average age of onset was 26 years.

The commencement of this variety appears to be sometimes abrupt, though it is usually more gradual and extends over a considerable period of time. The history is not as a rule satisfactory on this point. It may be taken for granted that prodromal symptoms are usually overlooked, and that consequently the duration before admission is in many instances much longer than is stated by relatives and others.

The figures concerning the time of onset are as follows:-

Up to one week before admission....	23 cases.
Up to one month before admission...	49 cases.
Up to six months before admission..	22 cases.
Over six months before admission...	26 cases.
Duration not stated.....	20 cases.

A history of previous attacks was obtained in 17 cases. These patients had been treated outside of the asylum, and after a remission had relapsed and been certified.

At first the symptoms are usually those of a mild depression or confusion. Less frequently the onset is marked by a slight excitement. Consciousness is usually clear, and orientation good. Hallucinations and delusions are frequent. They are often depressive, sometimes grandiose, and usually fleeting, changeable, and silly. They tend to disappear after a time. Associative disturbances are very characteristic. They are not always observed at first, but later the desultoriness and incoherence become prominent. Emotionally the patients are apathetic, though they may have periods of exaltation or depression. Their conduct is silly, irresponsible, and childish. They tend to be seclusive and unsociable. Mannerisms of all kinds are observed. The silly laugh or smile is very noticeable in this type. There is marked volitional disturbance. There is little appearance of interest or initiative. Stereotypy, impulsive acts, etc., occur,

but are not so prominent as in catatonia.

The course tends to be irregular, with unexpected and sudden phases of mild excitement, stupor, or confusion. Short rational periods may occur. The disturbances of association become more pronounced as the disease progresses, and the affective and volitional deterioration become more marked. Many patients have, however, a surprisingly good memory, are well oriented, and appear to observe what is going on around them, in spite of their emotional indifference and apparent lack of mental activity. Deterioration is fairly rapid, dementia usually supervening in a few months, though the course may be from two to three years. A few cases make apparent recoveries, but in most instances the disease terminates in fairly profound dementia.

The following figures show the outcome in 140 cases:-

Recovered.....	8.	(6%).
Slight dementia.....	28.	(20%).
Moderate dementia.....	32.	(23%).
Profound dementia.....	72.	(51%).

Illustrative Cases.Case 3580. Admitted 5/11/12.

On admission:- His expression is drowsy and self-absorbed. He is restless; his hands are always moving, playing about with his clothes. He adopts strange attitudes and maintains them for some time. He holds his arms across his face and chest in a protective manner. Asked why he did so, said, "Because my back is broken".

His attention is somewhat difficult to gain, and after each answer it obviously strays and he gazes fixedly at nothing. His comprehension of questions is good, and he recognises and names pictures correctly. He knows the name of the town, but cannot say what place he is in at present, as he has not been here long enough to find out. He is disoriented for time. There is no evidence of clouding of consciousness, and he obeys simple orders correctly and at once. At times there is a considerable delay before he replies, and at others he responds immediately. Occasionally he stops abruptly in the middle of a sentence, and after a pause



resumes where he left off. His memory for remote events is apparently good, but for recent is confused. He cannot give a good account of himself. He states that the police told him to come here. Some people, he does not know who, told the police that he had stolen a goat, which he had done. The goat was in his kraal, and so he just kept it. It belonged to another native, and was a male goat with two horns and two legs. Later patient said he was caught because of trouble in the kraal. A native, Dundeya, did not like patient, and went to a white man and got him to send patient here.

His conversation is very confused, and his replies to questions are frequently irrelevant and nonsensical. He does not appear to be hallucinated at present, but states that the boy, Dundeya, used to speak to him often at nights, though patient could never see him. Emotionally he appears to be quite indifferent.

Progress:- 19/11/12.

He is very silly in conduct. Laughs in a fatuous way when spoken to. He cannot say how long he has been here or what place this is.

He never speaks unless spoken to, but when addressed, he replies readily. His answers are however very ridiculous at times. He is hallucinated. His mother speaks to him at night, and sometimes during the day too. She says nothing at all. Later patient said that she asked him how he was getting on.

3/1/13. He is becoming worse. He takes no interest in anything and never speaks unless spoken to. His conduct is very silly. He laughs continually to himself. His conversation is extremely incoherent and he can give no account of himself.

5/5/13. His appearance is dull and stupid. When spoken to he smiles in a shy childish way, places his head on one side, and answers in monosyllables. He can give no account of himself. He takes no interest in his surroundings and is quite indifferent emotionally. His conversation is very silly and confused.

13/11/13. Dull and apathetic. He does not know where he is or how long he has been here. He grimaces slightly and smiles in a

silly way when spoken to. Quiet and unsociable.

26/5/14. Dull and demented. He stands in office with averted head, smiling in a foolish manner. He is quite disoriented for place and time. No evidence of hallucinations. He usually grunts in reply to questions, and if he does speak it is usually to answer "I don't know". He takes no interest in anything and never speaks to anybody. Very poor worker.

Case C.209. Admitted 10/12/13.

On admission:- He is quiet and self-absorbed. His expression is a little excited and anxious. Occasionally a foolish smile appears. He is correctly oriented for time and place, stating that this is a madhouse in Pretoria, that he came here yesterday, and that Christmas is due in a week or two. There is no apparent clouding of consciousness. He recognises common objects and pictures accurately, and promptly. His attention is somewhat difficult to gain, and is not easily held. He is not however distractible. At times he answers very irrelevantly, e.g., asked if anything was wrong

with him, replied, "These are very nice clothes I have on". His memory for events before admission is impaired. He gives a confused account of himself, and expresses many vague, persecutory delusions. He denies hallucinations at present but it is difficult to be sure of this. Asked if he ever saw spooks at night, replied, "Even if I do see them, I would not tell about them. I see them for myself". He denies hearing voices or anything unusual. Asked why he was brought here, answered, "I have nothing to say. They said to me at the pass office, 'You must not go away. This is your day to die' ". Patient states that he was told by a policeman that he had killed a white man. He himself does not remember doing so. He was told this a long time ago. When asked why the policeman should accuse him of murder, replied, "The policeman plays while we boys work". He states that he has been in Pretoria for two months, and during the first month he worked at the asylum here (incorrect). During the second month he worked for a white man in town. He does not know his master's name, - he had many names. He was working in the kitchen

and he was told he talked too much to himself. They told him he was mad. He looked at them and said, "Who?". "You are," they told him. He then looked hard at them and they made him mad. It was his master who made him so. He rambles on incoherently whenever a question is put to him. Says he is quite happy but would like to go home. Emotionally he is quite apathetic.

Progress:- 24/12/13.

He is worse. He cannot say what place this is. This is neither summer nor winter. He does not know when Christmas is due. Denies ever seeing A.M.O. before though he saw him a few hours ago. He is dull and confused. During the examination he kept his head averted, though he answered readily when questioned. In yard he sits by himself and takes no interest in his surroundings. He does no work.

7/1/14. He is now working well, and appears to be a little brighter. He is unsociable and never talks to anybody. He cannot say how long he has been here, but says this is a madhouse. He himself is all right. Says

he cannot remember being in the office before. Later when asked if he wanted to go home, replied, "I remember now being here before". He laughs and smiles inanely during the examination for no apparent reason. Quiet and gives no trouble.

10/3/14. Expression dull and indifferent. Stands in office with averted head. Whispers and smiles to himself, and occasionally laughs in an abrupt, foolish manner. When asked how long he had been here he replied, "I don't know. I just eat my food". No evidence of hallucinations. No definite delusions can be elicited. Poor worker. Rather worse.

10/5/14. He wears a constant frown. He grimaces slightly at times and smiles in an inane way. Disoriented for place and time. He cannot say why he was brought here. The police brought him. He had done nothing wrong. He was walking in the street late at night and a policeman caught him. He denies hallucinations. Nothing troubles him. He cannot say why he should be kept here. He is not mad. Asked if he had ever been mad, laughed in a silly way, and



after a pause said his head was wrong before,  
 but is all right now. Asked what made him think  
 he was mad at any <sup>m</sup>tie, said he thought he was.  
 His body was not right, and his stomach was sore.  
 His head was wrong in front, in his face, but the  
 back was all right. This was a long time ago.  
 His memory for events since admission is poor,  
 but he appears to remember certain things well.  
 Shown a percussion hammer, which he had not seen  
 since the day of his admission, he said he saw it  
 when he first came here, and explained correctly  
 how it had been used. Asked to explain his silly  
 laugh said that he saw the doctor and other people  
 in the yard, and that was nice for him. He has  
 shown no impulses or excitement since admission.  
 No evidences of stereotypy.

10/8/14. He smiles and laughs to  
 himself in a silly way, and talks incessantly in  
 a whisper. This last he denies. Asked why he  
 laughed, said, "At nothing." Says he knows the  
 name of this place but has forgotten it.  
 Pointed to the electric standard on the table and  
 said "That is the name of the place". He hears  
 a voice at night sometimes, but cannot say whose

it is or what is said. His conduct is silly and childish. Sleeping and eating well. He is becoming fat but mentally he is deteriorating. He is a poor worker. Has to be told everything he has to do, and works in a very mechanical way. Quiet.

15/11/14. He is very dull and stupid. He can give no account of himself. He is such a poor worker that he has had to be taken off work and kept in the yard. There he walks about, laughing to himself in a silly way and taking little interest in what is going on around him.

#### B. Catatonia.

This type of dementia praecox is less common than the hebephrenic. Of 214 male cases, and 47 female, 70. (33%) and 15. (32%), respectively, were of the catatonic variety. The average age of onset was 27 years.

Usually the development is of a subacute or chronic nature, but an acute commence-

commencement is more frequently found than in hebephrenia.

The figures of the duration before admission are as follows:-

Up to one week before admission.....	24 cases.
Up to one month before admission.....	18 cases.
Up to six months before admission.....	17 cases.
Over six months before admission.....	12 cases.
Duration not stated.....	14 cases.

A history of previous attacks was given in nine cases.

As a rule the attack is ushered in by symptoms of depression or confusion, just as in hebephrenia, which at this stage cannot be distinguished from the catatonic variety. This preliminary period is of variable duration, and is followed by catatonic stupor, or catatonic excitement, in both of which the volitional disturbances are marked.

In stupor the patient pays no attention to anything that is going on around him. He lies perfectly still, and cannot be roused. He does not react to strong stimuli such as shaking, pin-pricks, and so on. He does not speak. He requires to be fed, and does not attend to the calls of nature. Negativism and muscular tension

are prominent, and the patient strenuously resists any interference. In other cases there is a condition of hypersuggestibility. Muscular tension is absent, the patient reacts automatically to external stimuli, and catalepsy, echopraxis, and echolalia appear. Stupor varies in intensity, but there is usually a certain amount of clouding of consciousness. Occasionally however the memory for events during the stuporose period is astonishingly good.

Catatonic excitement is characterised by constant and purposeless activity. The patients shout, sing, dance, attitudinise, and perform weird antics. There is a tendency to the stereotyped repetition of the same words and actions. There is marked disturbance of associations, and the speech is very incoherent. These patients are inaccessible and difficult to get into touch with, but they frequently show a surprising clearness in the midst of the excitement. Sudden, impulsive acts are common, both in stupor and excitement.

Physical symptoms, such as vasomotor disturbances, pupillary changes, etc., are encountered chiefly in this form of the disease.

The course is irregular. Rapid deterioration may follow the advent of stupor without the appearance of excitement, and vice versa. Usually the two alternate, and there may be a pronounced periodicity. Stupor may exist unchanged for months, and excitement sometimes continues off and on for years before dementia supervenes. Short lucid intervals are often a feature.

Hallucinations and delusions occur, as in hebephrenia, especially during the acute stages. The emotional tone is one of indifference. Elation or depression may be found at the onset, but rapidly give place to apathy.

Deterioration is sometimes rapid, and may be pronounced in a few months. Usually the progress of dementia is somewhat slower, and occupies from eighteen months to two years. Remissions are not unusual, and may last for considerable periods. Recovery takes place in a few.

The following table shows the termination in 85 cases:-

Recovered.....9. (10%).  
 Slight dementia.....15. (17%).  
 Moderate dementia.....14. (17%).  
 Profound dementia.....47. (56%).

### Illustrative Cases.

#### Case 3602. Admitted 21/11/12.

On admission:- His expression is dull and vacant. He is clean and tidy in appearance. He stands quietly and gazes fixedly. His comprehension is impaired. He is very self-absorbed and his attention has to be roused for every question. Questions need repeating. Said he is a kalanga, is not married, and has no children. Apart from this answered "I don't know" to every question. Hence it is impossible to gauge his memory, orientation, or to acquire evidence of hallucinations or delusions. In yard he stands or sits alone all day. He will not speak, is unsociable, and takes no interest in his surroundings. Clean and dresses himself.

### Progress.

5/12/12. Answered to his name.  
 Repeated "I don't know" to all other questions.  
 Takes no interest and has to be dressed and



undressed. Stands or sits alone. Unsociable. Has not altered in any way. Very dull and stupid.

21/1/13. Refuses to answer. Sul-  
len in expression. Refuses food. Dirty in  
habits. Unsociable.

21/3/13. Put to work. Slow  
worker. Never talks. Sits quietly. Refuses  
food sometimes, which must always be brought to  
him. Silly.

21/5/13. Remains in same dull  
quiet state. It is impossible to gain any  
history from him, as his answers are generally,  
"I don't know". At times he will not speak at  
all. He takes no interest in his surroundings,  
sitting by himself, and never speaking with his  
fellow-patients. He will not work.

12/8/13. Now displaying marked  
negativism and mutism. Lies in bed taking no  
interest in his surroundings. When spoken to he  
turns away and pulls the blanket over his head.  
He shuts his eyes tightly and resists any attempt  
to open them. He has refused food the past week  
and has been tube-fed each day.

13/8/13. Sat up and opened his eyes today. He took his food voluntarily. Still refused to speak.

29/9/13. Two days after last note he refused food. Has been fed with a gag and feeding cup ever since. Never opens his eyes or speaks. Goes voluntarily to lavatory and opens his eyes then, and then only.

29/11/13. Refuses to speak. For past two days has been up. Takes no notice of anything. Somewhat resistive. Shows negativistic symptoms. Frequently goes off his food, when he does not eat and has to be fed. Lies in bed at these times with his eyes shut and resisting all interference.

14/2/14. Since last note has lain in bed curled up and with his eyes shut. Resistive. Marked muscular tension. Does not respond to pinpricks. Will not open his eyes or mouth when told. Sometimes goes to lavatory voluntarily, but at other times is wet and dirty. He opens his eyes, goes to lavatory, and when he comes back curls up in bed with his eyes shut and the blanket over his head. Never speaks and does not answer questions or obey orders. Has to be fed.

with gag and feeding cup.

15/4/14. Remains in a condition of catatonic stupor. Lies in bed all day and resists all interference. Has to be fed with gag and feeding cup. Sometimes goes voluntarily to stool. At other times is wet and dirty. Has shown impulsive violence of late, lashing out at anyone who touches him.

16/6/14. This evening he suddenly, without warning, attacked native attendant in hospital. Was violent and resistive and had to be put in Single Room to sleep. He opened his eyes to strike attendant. Afterwards shut them and kept them so, as he usually does.

13/8/14. Remains in a condition of stupor. Lies in bed all day, curled up and resistive. Has to be fed regularly.

26/10/14. Continues to lie in bed in a state of stupor. Resistive, and lashes out when interfered with. Requires feeding with gag and feeding cup. Lies curled up with his eyes tightly closed. He resists any attempt at passive movement, and often lashes out when interfered with. He sweats profusely. Occasionally gets up, opens his eyes, and goes to W.C. As a

rule he is wet and dirty. He never speaks, but a few days ago he suddenly attacked a bed-ridden patient in hospital, and the native attendant who intervened. He spoke one or two words, "Go on, go away".

15/12/14. He remains in a condition of catatonic stupor. Never speaks. Resistive. There is marked muscular tension. Habits wet and dirty.

Case C.214. Admitted 16/12/13.

On admission:- 17/12/13. He has been noisy and restless since admission. Last night shouted and sang most of the night. Quiet at present. Nothing special in appearance or expression. His voice is hoarse as if with shouting. He says he was brought here yesterday (correct). This is Pretoria Asylum. He was told he was being brought to Pretoria to work. He was brought here because he was blamed for stealing a bicycle. He did not steal it. He did not behave violently outside. The compound manager said he was drunk but this was not so. He used to make kaffir beer and sell it to other boys in the compound. He drinks a little,

regularly, but never gets drunk. Denies dagga. Memory and attention good. Recognises pictures accurately, and coins. There are 20/- in £. Three threepences from 2/6 = 1/9. Calculated fairly rapidly. There is no evidence of hallucinations. Says he was noisy last night because he was thirsty, and could not get a drink. Today there are no symptoms to warrant a diagnosis of insanity.

#### Progress.

19:12:13. Patient has been excited for past two days. He has been running about yard, dancing and shouting, and tearing his clothes. He has slept well at nights.

23/12/13. He is very restless, running about, shouting, interfering with other patients, attempting to steal, etc. At night he is particularly noisy, shouting, singing and hammering on his door:. He gives a very poor explanation of his conduct: e.g. says he smashed the single room because he had no work to do. He is lucid, correctly oriented, and his memory appears good. Emotionally he appears to be quite indifferent. He exhibits a few mannerisms

and a slight degree of stereotypy.

30/12/13. Last night he broke the window in his single room door and took out the lead. He has been noisy and restless, especially at nights, shouting and banging on his door. Along with this excitement patient shews considerable mental clearness. He is oriented and his memory and comprehension appear to be good. There is incoherence but no flight of ideas.

6/1/14. Remains in an acutely excited condition. Has shouted himself hoarse. Despite the excitement he appears to be well oriented and to appreciate his surroundings accurately. Likewise he shews evidence of stereotypy in certain remarks and movements accompanied by whistling.

13/1/14. Remains in a state of excitement. Shouts constantly day and night. Psychomotor activity is marked, but he is not emotionally elated. Despite the excitement he appears to be apathetic. His memory is good and he is well oriented.

14/2/14. Was working outside for about a fortnight until a week ago. Then he



refused to go, but gave no reason.

Has gradually become more excited.  
Is not elated. Rarely if ever laughs. Frequently violent, attacking other patients without warning and for no apparent reason. He tears his clothes to pieces. He shews marked psychomotor activity. Is constantly on the move. Exhibits distinct mannerisms and stereotypy, such as a peculiar prancing walk, a certain whistle he frequently repeats, and a hissing noise. He is oriented accurately for place, self and time. He can tell the day of the week and month accurately. He has no insight. He declares he is not mad and when asked to explain his behaviour, denies that his conduct is unusual: e.g., "Why do you make so much noise?" "No, Doctor, I don't make a noise. I make a basket for doctor. Doctor give me string. I make a basket." His attention is readily obtained but wanders markedly. He draws and writes fantastically on the pavement in yard. He would not explain the drawings when asked what they represented and could not say what the various figures and letters indicated. He has a good idea of the

passage of time. Thus he says he has been here one month and 21 days (2 months). His memory for events since admission is good. He appears to have developed hallucinations. Says that God talks to him at nights. He can see Him. Cannot say what God says to him, or how he knows that it is God who appears.

14/3/14. Not improved. Noisy, shouting, and running about night and day. His voice is hoarse from continued shouting.

16/4/14. Remains in an acutely excited state. Asked what place this is said "I don't know". Later said it was a hospital. His attention is difficult to gain and readily wanders. By frequently repeating questions it is possible to gain a little information from him. Despite his excitement he appears to comprehend his environment fairly well. Recognised and named accurately common objects and pictures. Hallucinated. Admits people speak to him when he does not see them. Says there are two people. They call him bad names and say he has killed someone. They want to kill him. His conversation is very incoherent and

disconnected. He says that the people (above) who call him names sometimes appear to him at night. They do not frighten him. He is very happy, he says. He does not appear to be elated, however, and but rarely is seen to laugh. He exhibits numerous stereotypies in conduct and conversation. He moves his arm in the fashion of hammering and accompanies each stroke with a guttural expiratory sound "ach, ach, ach." He is not violent in yard. Decks himself at times in a fantastic way. Tears his clothing. At nights is noisy and excited. Denies that he is mad. Can give no explanation of his conduct. Somewhat resistive and negativistic, e.g., if asked to come here, he runs away; told to leave office, had to be dragged out of it. Shouts incessantly thus; "No, yes, yes, ach, ach, ach, I shall kill a white man, yes, yes, no, I shall kill a white man, no, what do you say, ach, ach, ach," and so on, all this accompanied by stereotyped movements of arms and stamping of feet, grimacing and twisting about. Is developing insane ear on right side.

17/5/14. He remains in a condition of acute excitement. He shews the same

stereotyped movements and sounds noted last month. He is very inaccessible. Questions have to be shouted at him repeatedly and it is but rarely that he will answer. When he does however he replies correctly. He named correctly a few common objects when they were held in front of him and he was asked repeatedly what they were. He did not reply to other questions. In yard he is noisy and excited. He strikes other patients and is very mischievous. At nights he is noisy and sleepless. Paraldehyde, hyoscine, and morphine have practically no effect. His habits are filthy. He smears his room with faeces, throws his food about, covers himself with mud, and tears his clothing. Physically he is much thinner and is losing weight despite extras.

17/6/14. He maintains his nutrition despite a constant excitement. He snatches food from other patients. Very dirty. Throws his food on ground and eats it when covered with dirt. Noisy restless and excited day and night. Continues to shew same stereotyped movements. He has a swelling on the right side of face with constantly hitting himself there. He is practically quite inaccessible. Does not reply to

questions, and yet appears to be fairly clear mentally and to notice what is going on around him: e.g., when Assistant Physician was examining the swelling on his face patient said, "Don't want knife there. Sh-- sh--". He is not wet and dirty but at nights sometimes smears his room. He is very untidy. He interferes with the other patients in a senseless way. He shews copious salivation, and allows the saliva to trickle out of his mouth. He always keeps to the one corner, where he continues his stereotyped movements and noises.

9/7/14. Quieter, Put to bed as he seems to be very exhausted. Has been quiet and slept well since put to bed.

13/7/14. Was noisy last night for three hours, getting out of bed and rolling on floor. He still exhibits stereotypy; continues to make expiratory grunt as he lies in bed. His breath is very foul. He salivates.

14/7/14. Signs of consolidation at the right base. Temperature normal, Pulse 120 and weak. Respiration 36.

15/7/14. Died. Lobar pneumonia.

### C. Paranoid.

This is the least common form of dementia praecox, and usually commences somewhat later in life than the other two.

Out of 214 male cases, and 47 female, 30 (14%) and 6 (13%), respectively, were of a paranoid type. The average age of onset was 30 years.

The development tends to be chronic, though it is occasionally fairly rapid.

The figures concerning the duration before admission are as follows:-

Up to one week before admission.....	4 cases.
Up to one month before admission....	6 cases.
Up to six months before admission...	8 cases.
Over six months before admission....	10 cases.
Duration not stated.....	8 cases.

In no case was there a history of a previous attack.

At first there is often a period of depression or confusion, similar to what is found in the early stages of hebephrenia and catatonia. Afterwards delusions appear. These are well developed, and constitute one of the conspicuous



and characteristic features of this form of the disease. They may be depressive and persecutory, but are just as frequently grandiose. The two may be combined in the same patient. Partly on account of the feeble reasoning powers of the native, it is rare for the delusions to be even loosely systematised. They are often silly and changeable, and are usually accompanied by corresponding hallucinations, especially of hearing.

Orientation is good, and there is little or no clouding of consciousness. Emotionally there may be depression, or exaltation, but often there is observed a striking indifference, and the patients may relate their experiences in an off-hand, matter-of-fact way. At first there may be no abnormality of conduct noticeable. These cases are inclined, however, to be shut-in and inaccessible, and there may be some excitement, silliness, or dulness.

The course is progressive. The delusions persist throughout, though they tend to become more indefinite and incomprehensible with the continuation of the disease. In the final stages they may disappear entirely. The

hallucinations likewise continue, though less attention is paid to them as time passes. They may sink into abeyance, and reappear along with delusions, during an excited episode.

The characteristic associative disturbances may not be noticeable at the commencement, but appear early, and become progressively more marked. The incoherence may be extreme. Peculiarities of conduct develop in most. There is a steady deterioration in the emotional life. Irregular phases of excitement and stupor are fairly common.

In some cases the course is rapid. In others the progress of deterioration is slow, with periods when the disease appears to be at a standstill. Usually this variety of the psychosis terminates after a few years in slight or moderate dementia.

The following figures show the outcome in 36 cases:-

Recovered.....	Nil.
Slight dementia.....	18.(50%).
Moderate dementia.....	10.(28%).
Profound dementia.....	8.(22%).

Illustrative Case.Case 3571. Admitted 30/10/12.

On admission:- His appearance is clean and tidy and his expression is interested. He stands quietly and fixes his gaze on the questioner. His power of attention is good, easily obtained and does not tend to stray. His comprehension of questions is good and his speech normal. He answers readily and well but is inclined to become garrulous. His remote memory is excellent, and he readily remembers incidents of the war and gives its dates correctly, 1899-1902. His recent memory is also good but at times he is a little confused. He is correctly oriented for self and place. Says this is Pretoria and the yard is a madhouse. Time appears to be correct. He can say how long he has been here but cannot name the day. He names the month with a little hesitation. His psychomotor activity is normal, his emotions stable and as yet he has shown no impulses. In the yard his conduct has so far been rational. He is quiet, sleeps well and takes his food well.

Is sociable and takes an interest in his surroundings. He denies brandy, Kaffir beer, and dagga. Shewn the dagga pipe he said the Zulus were using it to bewitch him. He can feel them using it but has not seen them. He has hallucinations of hearing and delusions of persecution, and he enlarges on and voices these freely. He says that during the war the soldiers in the Army Service Corps wanted to shoot him, (and he mentions two names). He heard these men talking about it. All the garrison said, "Antoni's the best driver in the camp and must be shot". They were jealous of him. He was called "Imperial Joe Menas Up-to-date, Esq." As people walk past him, they talk about him. They say the Government have given him money, cattle and a white wife, etc. They are jealous and say the Government have given him too much. He has never said these things himself nor does he think them or believe them. But people say them. He has told these people to stop. These people have bewitched him and tried to make his head wrong. They sent a cat under the bed, he couldn't sleep, so tried to drive it away. Then

he threw a stone at it and an Indian said the stone was a bullet. Then he took a spade and drove it away. They talk in his ears day and night. One night he took a Bible, a Hymnbook and a candle and placed them on his left hand to stop them. They said "Coolie, coolie, coolie", and "We're going to bat, bat, bat." He has heard them speaking in gaol, and also last night in yard, and in his room. He never sees them.

14/11/12. Retains his delusions of persecution. A good and willing worker. Well behaved.

28/11/12. Says he is accused of being mad. He isn't. But there is something wrong. He feels in his head that someone is speaking though he can't make out who it is. He hears someone calling "Cooee, cooee". Well behaved and an excellent worker.

30/12/12. Says he is better in a way. Works well. Hears people talking day and night. Can't make out what they say.

28/4/13. Working well with hall porter. He talks in a grandiose manner using quite good English. He retains his hallucinations and delusions.

12/7/13. Continues quiet and well behaved. Working in hall porter's office. No real improvement.

7/10/13. No insight. Retains his hallucinations and delusions. Rather exalted. Correctly oriented for time and place. People have recently been here with a crowd of cats to bewitch him. He is not mad, has his full understanding and won't be bewitched.

9/1/14. Works well in hall porter's office and in dispensary. Retains his delusions of persecution. They do not seem to affect him emotionally. Says he is very much troubled by a Malay girl and two Dutchmen sitting on his heart and talking to him. He never sees them. Tells this story in a matter of fact way, with frequent laughs. There is no system about his delusions. His story is very disconnected.

11/4/14. Yesterday became excited and had to be brought back to the yard. Interviewed today explains that the doctors, the clerk, the hall porter, the matron and various others are using bad stuff. Will not explain what he means by this, except to say that it is



Satan's stuff. Is actively hallucinated at times. Says he hears pistols and revolvers under the ground behind native yard. Day before yesterday he saw a ghost at front door of main building, and at other times ghost of a white girl. Very incoherent. Laughs in a silly way. Says that these things do not frighten him., because he has an angel hooked on to him.

16/9/14. No improvement. He is well oriented. States exactly when he came here, giving date. He grimaces and smiles in a peculiar manner when spoken to. He occasionally laughs in a mirthless way. He is inaccessible. Questions have to be repeated frequently before he replies, and his answers are often irrelevant. He has no insight. He is quite sure that he is not mad. He is actively hallucinated, and expresses numerous absurd delusions. States that he has two Malay women inside him, one on the right side of his chest, and the other on the left. He knows they are there because he can hear them speaking and can speak to them. They talk nonsense. They have no minds, but are in the best part of him, and therefore know what anyone says to them. They do not trouble him.

They both used to be on the left side of his chest, but about a year ago, one of them went up to his head, through his brain, and down to the right side. He felt her going through his head, and heard her. She made a noise like this, "Sister-fits, sister-fits,...." His conversation is very rambling and disconnected. Thus, asked how the Malay women managed to get inside of him, replied, "They used to be above. 1912 that was. You know the Scotch band. They only could get at my knees. 'Listen to what I say', they said. I can prove it. There is no sense", and so on. He says that he also hears other Malay women when it rains. They say they are "Maradicals". He cannot say what this means. Thinks it may be the nation to which they belong. He sleeps well, he says, but sometimes at night sees the doctor flying in the air; not very high up. Sometimes he sees other people. They vary, but he always sees somebody. At nights when patient returns from work, he walks round in a prancing way for hours.

28/12/14. He is much the same.

He is correctly oriented for place and time and

has a clear comprehension of his environment. He grimaces, and laughs to himself in an abrupt, foolish manner. He talks readily without being questioned. His conversation is incoherent and confused. Emotionally he is apathetic. He has indefinite persecutory delusions and appears to be actively hallucinated. States that at nights he hears various people in the asylum speaking to him from the sky. They call him nasty things. In spite of repeated questioning patient always avoids saying what the nasty things are. Every night, he says, he sees ghosts and Satan, but he does not bother about them now. He thinks the doctors and the matron are responsible for these things happening, but cannot say why they should wish to annoy him. Later said it was because he knew too many things about them. He still has two Malay women in his chest, one on each side. He is unsociable and never mixes with other patients. A good worker. Quiet.

For purposes of comparison the figures in each of the three varieties are shewn in tabular form side by side. (Tables XII & XIII).

Table XII.Dementia Praecox: Varieties.

	Number of cases.	Males.	Number of cases.	Females.
		Rough Percentage.		Rough percentage.
Total.....	214.	-	47.	-
Hebephrenia..	114.	53.	26.	55.
Catatonia....	70.	33.	15.	32.
Paranoid.....	30.	14.	6.	13.

Average age of onset.

Hebephrenia.....26 years.

Catatonia.....27 years.

Paranoid.....30 years.

Table XIII.Dementia Praecox: Varieties.Mode of termination.

	Hebephrenia.	Catatonia.	Paranoid.
Recovered.....	6%.	10%.	Nil.
Slight dementia....	20%.	17%.	50%.
Moderate dementia..	23%.	17%.	28%.
Profound dementia..	51%.	56%.	22%.

#### D. Mixed Forms.

Though the cases have been included, for statistical purposes, under one or other of the three main forms, it is the exception, rather than the rule, for the types to be sharply defined. Symptoms most characteristically developed in one variety are often present in the others. The same case may pass from hebephrenia into catatonia, and so on. These facts merely emphasise the fundamental unity of the three types.

#### V. DIAGNOSIS.

No special symptom can be regarded as pathognomonic of dementia praecox in natives. The diagnosis must be based on a consideration of all the symptoms, together with the mode of onset, course, and termination. There is often considerable difficulty experienced at first, accentuated in most cases by the absence of any reliable history. The chief signs to be looked

for are associative defects, shown by irrelevance, desulteriness, and incoherence; emotional dulness; peculiarities of conduct, and disturbances of volition, such as stereotypy, automatism, and negativism. In addition, silly delusions, with or without hallucinations, are of importance. Time is often required before a definite diagnosis can be arrived at.

### 1. Hysteria.

Natives are on the whole very suggestible, and many of their emotional outbursts must be regarded as hysterical in nature. It is doubtful, however, if true hysteria occurs. Some cases of dementia praecox show symptoms, which, on superficial examination, simulate those of hysteria, but further enquiry reveals an emotional indifference and purposelessness of conduct incompatible with true hysteria.

### 2. Manic-depressive Insanity.

The depressive phases of this form of insanity are comparatively rare in natives, but may be confused with the early stages of dementia praecox. The presence of hallucinations and



senseless delusions are in favour of the latter psychosis. The typical sadness of the melancholic is absent, and there is no true retardation.

The manic type of manic-depressive insanity is fairly common, and has to be distinguished from the excitement of catatonia. Manic patients are more in touch with their environment. They show distractibility, which is exceptional in dementia praecox. Though it wanders readily, their attention can usually be gained momentarily, while in dementia praecox it is often difficult to get into touch with the patient at all. They exhibit confusion and disorientation in accordance with the degree of excitement: they do not have that mental clearness so often found in cases of catatonia. Their acts are irregularly directed but not purposeless. They do not show the same tendency to meaningless stereotypies in speech and conduct; their behaviour is more comprehensible. There is more connection in the sequence of thought, and incoherence does not occur out of all proportion to the degree of excitement. Their emotional tone is one of elation, in place of the indifference characteristic of dementia praecox.

3. Toxic Insanity. (Dagga. Alcohol).

Dagga insanity may simulate very closely the excitement or stupor of catatonia. A history of dagga smoking may assist somewhat, but is not conclusive, as it is often got in other forms of mental disorder. In excited conditions due to dagga the psychosis is characterised by confusion with marked clouding of consciousness, very different from the mental clearness so often seen in dementia praecox. Hallucinations are prominent, and are reacted to in a pronounced manner rarely observed in schizophrenics. Emotionally the patients are apprehensive or exalted instead of apathetic. The course is short, recovery usually taking place in a few days. It has been stated that relapses after a short period are a feature of dagga insanity. It may be taken that these relapses are due to one of two things, either the patient has obtained dagga surreptitiously, or the diagnosis of dagga insanity has been wrong. In any of the other toxic insanities relapses do not occur as long as the drug is withheld, and

it is difficult to see why dagga should differ from other narcotics in this respect. If a relapse occurs, and if dagga smoking can be definitely excluded as its cause, the case may be considered one of dementia praecox, in which disease such lucid intervals are frequent.

Stupor following excessive smoking of dagga may be very difficult to distinguish from catatonic stupor. There is however in the former an absence of volitional disturbances, such as negativism, and automatism. A rapid recovery without relapse indicates dagga as the etiological factor.

Alcohol is usually taken by natives in the form of Kaffir beer, the intoxicating properties of which are slight. Strong spirits, such as whisky and brandy, as a rule can only be obtained at irregular intervals, on account of the stringent laws in connection with liquor selling to coloured races. Delirium tremens, hallucinosis, and the other psychoses due to chronic alcoholic poisoning are therefore extremely rare in natives. Sometimes, however, after a drinking bout of illicitly obtained and crude

spirits, there develops a condition of excitement or of stupor, lasting for a few days, and corresponding very closely to what is observed in cases of dagga insanity.

#### 4. Paresis.

Though syphilis is rife amongst the native population, paresis, for some reason hitherto unexplained, is extremely rare, and therefore, though it may give rise to confusion with Europeans, before the appearance of definite physical symptoms, it does not require to be eliminated in the diagnosis of dementia praecox in natives.

In a doubtful case paresis can be excluded by the failure to find <sup>in</sup> the cerebro-spinal fluid evidences of a positive Wasserman Reaction, lymphocytosis, or globulin.

#### 5. Epilepsy.

In the absence of a history, epileptic befogged states may offer some difficulty. The confusion is here more marked than in dementia praecox, negativism and catalepsy are absent, and

the emotional attitude is one of apprehension and anxiety, rather than of apathy.

It has been pointed out in the chapter on general symptomatology that epileptiform attacks are sometimes observed in cases of dementia praecox in natives, and so a diagnosis of epileptic insanity should not be made merely because of the occurrence of convulsive seizures.

#### 6. Imbecility.

As a satisfactory history is rarely obtained with natives, slight degrees of imbecility may at first be difficult to differentiate from the early stages of dementia praecox. Childish behaviour, defective memory, and failure to recognise and name common objects or to do simple calculations, along with an absence of characteristic associative disturbances, speak for imbecility. Also the cases are stationary and do not deteriorate, unless, of course, complicated by an attack of dementia praecox superimposed on the imbecility.

## VI. TREATMENT.

Treatment is purely symptomatic.

The state of the alimentary tract usually requires attention. Excitement may necessitate the employment of one or other of the commonly used hypnotics. During the acute stages the nutrition requires to be maintained by the giving of extras, in the shape of milk, eggs, and other forms of easily digested food. Manual labour, suited to the mental and physical capacity, constitutes the chief therapeutic agent.

## VII. SUMMARY.

Briefly summarised, the observations detailed in the preceding chapters are these:-

1. There occurs in the native races of South Africa a dementing psychosis, comprising one-third of all cases of insanity, and developing characteristically at the adolescent period of life.



2. The etiology is obscure. While predisposing and exciting factors of various kinds play an important part, the real pathogenetic cause is unknown, although facts seem to indicate the existence of some endogenous toxin acting adversely on the central nervous system.

3. The symptoms generally are those of a definite mental enfeeblement, characterised by associative defects, emotional deterioration, and volitional disturbances, often accompanied by delusions and hallucinations, while other mental spheres are not correspondingly attacked.

4. Different clinical types can be recognised, each with a more or less defined symptomatology and course, but there exists no line of demarcation between the various forms, this being true of any individual case, and of the disease in general.

5. The course varies markedly, but the general tendency is towards rapid deterioration, terminating in more or less profound dementia.

6. The disease can be differentiated from other psychoses occurring in natives.

In view of the foregoing facts we can conclude that the psychosis, dementia praecox, as described in Europeans, occurs also in the native races of South Africa. The dissimilarity of some of the symptoms is to be accounted for by the different mental constitution in which the disorder develops, and not by any fundamental difference in the disease process itself.